Adelaide Health Centre

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information we hold about quality, and information given to us from patients, the public and other organisations.

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Overall summary

Solent NHS Trust provides community and specialist healthcare services to a population of over a million people living in Southampton, Portsmouth, South East and South West Hampshire. Some services extend across the whole of Hampshire, including sexual health services and community dental services.

Solent NHS Trust HQ is based at Adelaide Health Centre and this report relates to community services provided trust wide, and is not limited to those provided at the health centre. Trust wide services are provided from over 120 different locations including community and day hospitals, as well as outpatient and other settings within the community such as health centres, children's centres and service users homes.

During our visit we held focus groups with a range of staff across community health services. These included ward nurses, health care assistants, community nurses, community matrons, health visitors, school nurses, allied health professionals, doctors, dentists and administrative staff. We observed how people were being cared for, talked with carers and/ or family members and reviewed personal care or treatment records of patients.

Overall we found that community services were safe. Staff understood the importance of reporting untoward incidents and were confident and willing to raise concerns. The Trust had systems for collating and investigating incidents and there was evidence of improvements arising and some sharing of learning across services.

Most people working at the service said that they felt there were enough staff and the Trust was taking a proactive approach to check that there were enough staff to keep people safe and meet people's needs. However some district nurse teams and the rapid response team in Southampton were finding it hard to meet demand and the recruitment of staff was ongoing. We found the leadership and sharing of productive and effective ways of working across the Southampton and Portsmouth community teams could be improved.

Generally there was good access to services and these were responsive to the differing needs of patients. An excellent service was provided to homeless people in Southampton, and the community dental services provided exceptional care to patients, children and young people with special needs. But we found there was insufficient capacity at some busy sexual health clinics. There was a risk that patients turned away from these clinics would not receive timely treatment, or may not receive treatment at all.

Staff used pathways of care to treat patients, based on nationally agreed best practice. There was good multi-disciplinary and multi-agency team work taking place. We found examples of innovative practice and excellent care which enabled patients, children and young people to receive care at home, or close to home, and avoid admission to an acute hospital.The Children's Outreach Assessment and Support Team ("COAST") was particularly notable.

We found a high level of patient satisfaction across community services. The majority of people commented on the caring and compassionate approach of staff across the organisation. Staff were highly motivated and committed and treated people as individuals. We observed that patients were treated with dignity and respect. End of life care and in particular the Portsmouth specialist palliative care team was notable.

We found examples of good leadership and staff felt they were well supported by their managers. Staff were aware of the trust's objectives and values and felt well-led by all levels of the organisation. Many said they had good supervision, training and development opportunities.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

We judged that overall community services were safe. There were systems to identify, investigate and learn from incidents. Staff at all levels of the organisation said there was an open culture that supported them to report and learn from incidents. The trust's board had a focus on quality and this was reflected across the organisation.

There were safe systems, processes and practices for example medicines were handled safely within community services. Generally we found that there were safe staffing levels but the capacity of some community nursing and the Southampton rapid response team were stretched. The Trust was aware of risks and monitoring regularly but was still working on determining on 'safe staffing levels for community teams'.

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 excellent mutli-disciplinary working and initiatives to support people at home and avoid admission to hospital.

Some services were measuring their performance and effectiveness but this was not well established in all services such as district nursing and community matrons. It was not clear that these teams were always making the most effective use of resources across localities and the trust as a whole.

Are services caring?

Patients were overwhelmingly positive about the quality of service that they received. We saw care being delivered across a wide range of services, and staff treated patients with compassion, kindness, dignity and respect. Patients told us that they were involved in planning their care and that they were provided with enough information to make informed decisions.

Staff were passionate about the care they delivered. This was reflected in the comments made by patients and their relatives.

Are services responsive to people's needs?

Generally services were accessible and responsive to people's differing needs. We saw good examples of person-centred care and services that were adapted to meet specific needs. Staff provided a range of evidence as to how they had developed or enhanced their services to respond to feedback from patients.

However there was insufficient capacity at some busy sexual health clinics which meant that patients were turned away. This meant that these patients could not receive timely treatment, or may not receive treatment at all.

Are services well-led?

We found that community services were well-led. Staff felt well supported and displayed a commitment to the values of the organisation and best quality care. This was reinforced by a local and senior leadership who helped to motivate staff and reward patient-centred practice.

There were organisational, governance and risk management structures in place which were working well. Staff said that they felt supported to raise any concern and that the culture of the Trust encouraged them to do so. Staff were provided with opportunities for training and professional development.

Summary of findings

What we found about each of the core services provided from this location

Community services for children and families

We found that the children's and families' service was safe, effective, caring and in the main responsive to the needs of the local population.

Services are generally safe. There were arrangements in place to minimise risks to children and young people receiving care and staff working alone in the community. Staffing levels were generally safe in the services and there was consistency in incident reporting practice. There were effective systems in place to learn from incidents and sharing of that learning both within individual teams and across the organisation. We were told by staff that there were some inconsistencies in the recording of training.

Services were generally effective, evidence based and focussed on the needs of children and young people. We saw some examples of very good collaborative work and innovative practice. The Trust was making changes to ensure the different parts of the service worked together to provide an effective service across the region. The majority of services' governance arrangements ensured a robust process of information sharing between operational services and the Trust Board. Most teams had a clear overview of their own performance and outcome measures which were based on the needs of the population.

The vast majority of people told us they had positive experiences of care. Parents and carers felt well supported and involved with their children's treatment and told us that staff displayed compassion, kindness and respect at all times. Many staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to people and their representatives and the values of the organisation they worked for.

We found the children and families service was responsive to people's needs and people from all communities could access services. Overall we found that effective systems were in place to ensure that children, their relatives and those close to them received the support they needed in the community, despite some differences in local commissioning arrangements.

The service was in general well–led with effective decision making and strategic planning. There were risk management systems in place across the service and generally staff had a clear oversight of risks to quality in the organisation. Innovation was encouraged by the leadership of the service and this led to improvements in the delivery of services.

Community services for adults with long-term conditions

Overall we found that because community teams provided a coordinated and comprehensive service, people with long term conditions received safe care.

There was good communication between inpatient locations and community services which meant that people were supported effectively to improve or maintain their health and welfare and reduce the need to return to hospital. There were clear examples of effective multidisciplinary working across teams and with other organisations. There were excellent services that improved health and wellbeing for vulnerable people such as the homeless. We saw examples of how the services promote safe care by monitoring and learning from incidents, and using a range of benchmarking activity comparing against national and regional performance. Teams and specialist practitioners worked within accepted research based guidelines.

We were concerned about safety of patients being supported by some of the community based teams. This was due to staff deployment, especially out of hours, not matching demand in some localities. This had been identified by the Trust as a risk but had not been fully resolved although staff had been recruited for some teams. To monitor the risk the trust had a system whereby staff levels were reported to the senior nurse each day.

Summary of findings

Services were effective as staff worked in a robust multidisciplinary way that meant patients were supported through the phases of their illness and to remain at home. There were many examples of good liaison with hospitals or inpatient units to promote early discharge or to prevent hospital admission. There was effective monitoring of the performance of teams to support people with long term conditions through reporting within teams and to the trust managers. There were specialist nurses, and therapists who provided expert advice across teams. Consultant medical staff or general practitioners led some areas of the service such as clinics and community virtual wards which meant that medical decisions could be made along with the multidisciplinary clinical team

Services for people with long term conditions were caring. In our discussions with patients and relatives or carers we found people were mostly very satisfied with the care and support they received. Patients receiving rehabilitation and ongoing care described being well supported by a team of staff who recognised their needs and agreed plans of support with them. We observed staff providing compassionate care and consulting with patients in clinics and in their homes. In several teams we saw that patients were allocated a key worker with whom they could build a trusting relationship and who ensured wider needs were met to promote health and welfare.

The staff in community and inpatient services of the Trust worked in multidisciplinary teams and collaboratively with patients to provide care and treatment that met patient's needs. This enabled people to stay at home as they managed living with long term conditions or to recover from acute phases of their condition.

Specialist clinics in community locations had been established by the Trust where staff provided expert advice at appointments or rehabilitation sessions. The Homeless Healthcare Team provided an excellent service for homeless people who could receive support for long term health issues such as diabetes and including screening for liver disease. People with rheumatoid arthritis were supported to sample exercise or relaxation sessions that may be of help to their condition and also encourage social interaction.

Services were well-led because the Trust had developed a clear strategy to support people long term conditions. Managers and staff had been restructured in a way that promoted integration of services for those patients living with long term conditions or receiving rehabilitation to improve their health and welfare after injury or acute episodes. Needs assessment in the area covered by the Trust had shown that increasingly people will have multiple health needs. To manage this the Trust had developed teams that included a range of specialists to work in a multidisciplinary way and to enable complex case management. The Trust had established central points of access and clinics for people needing care, treatment and advice about their conditions. Staff said they were able to openly discuss any issues about patient care and safety with their managers. Staff told us they were supported to develop skills and knowledge and continue to develop their professional competencies to support the complex needs of patients they cared for.

End-of-life care

We found that the end of life care service was safe, mainly effective, caring and responsive to the needs of the populations it served. The end of life care service was outstandingly well-led in Portsmouth.

Services were safe. There were arrangements in place to minimise risks to patients and to staff working alone in the communities. Staffing levels were appropriate to the needs of the service. There was a consistent approach to reporting incidents and these were generally well followed up and the results fed back to staff. There were effective systems in place to learn from any reported incidents. However, sharing of information across both teams was not common practice.

Services were generally effective, evidence based and focused on the needs of the patients requiring end of life care, and their families. We saw and heard of some examples of excellent collaborative practice and this added value to the experience of the patient being cared for.

Summary of findings

Services were exceptionally caring. Patients and their families told us how well cared for and well supported they felt by the end of life care services. All care was delivered with respect, specific knowledge and great compassion. Staff were clearly proud of their service and actively made plans to further improve it.

Services were responsive to the diverse needs of the populations it served. We found that they took note of individual requirements and ensured that anyone who wished to access the service was enabled to do so.

Services were exceptionally well-led in Portsmouth, with effective direction, planning and clear decision making and communication. Risk management systems were in place, and staff were fully aware of their responsibilities in reporting and in implementing new practice.

Other services: Sexual health services

People using the service told us they felt safe and were mostly treated with respect by the staff who were non-judgemental and reassuring. Some people said the waiting arrangements for walk-in clinics made them feel vulnerable and there was a lack of privacy when speaking with reception staff. When people were turned away from clinics, because they were already full, the conversations were not always managed sensitively. The layout of premises at different clinics meant that people were not always afforded adequate privacy whilst waiting to see a clinician.

The service was not always able to meet people's needs in a timely way. Staff endeavoured to see people by informally extending clinic times but at some clinics patients had to be 'turned away' and there was a risk that they may not receive the treatment they needed. The capacity of some clinics had reduced recently to accommodate a new information management and technology (IT) system and this meant patients were sometimes asked to come on a different day. Patients' views were sought to inform service design and changes had been made as a result of patient feedback. The service had staff vacancies however, which meant that clinics were sometimes closed at short notice, or provided a reduced service.

Services were safe because there were systems for identifying, investigating and learning from patient safety incidents and an emphasis in the organisation to reduce harm or prevent harm from occurring. Action had been taken to improve patient safety following incidents, which reduced the risks to patients and staff. However, improvements to patient and public safety in relation to cancelled clinics and waiting times were required.

The service took account of guidance and best practice issued by national bodies and audited its practices and performances. Staff received regular training and supervision, and were supported to gain additional qualifications and undertake research. There was effective multidisciplinary working across the service. Working with a range of partners and other services meant patients received their care in a joined up way.

The Trust's strategy and vision was embedded and staff reported good leadership and co-operative team working. Organisational objectives, risks and performance were monitored through clear governance arrangements.

Other services: Community dental services

We chose to inspect parts of the dental service across the area as part of the first pilot phase of the new inspection process we are introducing for community health services.

Overall we found dental services provided safe and effective care. Patients' were protected from abuse and avoidable harm. Systems for identifying, investigating and learning from patient safety incidents were in place.

Dental services were effective and focused on the needs of patients and their oral health care. We observed good examples of effective collaborative working practices and sufficient staff available to meet the needs of the patients who visited the clinics for care and treatment.

Summary of findings

All the patients we spoke with, their relatives or carers, said they had positive experiences of their care. We saw good examples of care being provided with compassion and of effective interactions between staff and patients. We found staff to be hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed how dedicated they were in what they did.

At each of the clinics we visited the staff responded to patient's needs. We found the organisation actively sought the views of patients, their families and carers. People from all communities, who fit the criteria, could access the service. Effective multidisciplinary team working ensured patients were provided with care that met their needs, at the right time and without delay.

The service was well-led. Organisational, governance and risk management structures were in place. The senior management team were visible and the culture was seen as open and transparent. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns.

Summary of findings

What people who use the community health services say

We spoke with a range of patients and relatives during the inspection and with patient representative groups before the inspection. We also held listening events and spoke with patient representative groups before the inspection. We gathered comment cards from patients and relatives prior to and during the week of the inspection.

The feedback on services was overwhelmingly positive. People told us that staff were caring, that care and treatment met their needs and they felt listened to by staff and involved in decisions about their care. There was some negative feedback from patients attending sexual health clinics about long waiting times, lack of clarity about clinic availability and the risk of being turned away.

Most, but not all, community services carried out regular patient surveys and these showed that the majority of patients were satisfied with their care. For example, overall patient satisfaction for the community stroke service was 98 per cent positive for the year to March 2014. In the cardiac rehabilitation service a patient experience questionnaire was given to every patient on completion of their course of rehabilitation. February 2014 results showed 98 per cent satisfaction.

The trust has recognised a need for improving levels of patient feedback across all services and commissioned an internal review 2013-14. The draft report November 2013 cited the range of trust wide mechanisms used to gain feedback including the Family and Friends test. The results collected by the Trust between the period of April 2013 to September 2013 showed that from 1,738 responses collected, 1,332 patients 'were extremely likely' to recommend and 320 patients 'were likely' to recommend the Trust services to family and friends. Under 5% of patients provided a negative response.

The higher the Friends and Family test score, the more likely people are to recommend the trust's services. The score can range from 100 to -100. With the exception of August, the Trust consistently scored above 75 from April 2013 and scored 80 in January and February. The response rate for January and February was low at under 5%, but the findings were consistent with what people told us during inspection in March .

Areas for improvement

Action the community health service MUST take to improve

- People were not always able to access sexual health services as waiting times were sometimes long for walk-in clinics and people were at risk of being turned away. Clinics were sometimes cut or cancelled if the required number of trained staff with the appropriate skill mix were not available. Actions taken by the Trust to improve access to the service have not been sufficient to ensure people were seen within national guidance timescales. The Trust must ensure the services are planned and delivered to meet people's specific needs, to protect their safety and welfare.

Action the community health service SHOULD take to improve

- The Trust should review the effectiveness of Information Technology ("IT") systems, in the short term as well as long term, to ensure that staff have efficient access to and use of computerised records.
- The Trust should consider ways to promote information sharing and learning to increase effective and productive practice across all service areas, in particular all community nursing teams, at locality level and trust wide.
- The Trust should continue to review the staffing levels and case loads of community nursing teams to ensure delivery of safe and effective care and to release staff

Summary of findings

for training and development. The size and skill mix of community nurse teams should be reviewed to ensure a good match with the locality or GP population that each team serves.
- The lack of capacity for physicians in the Looked After Children's ("LAC") service meant not all new assessments and reviews of care needs were carried out within the target timescales and is an area the Trust should consider as a priority to action.
- The Trust should review current arrangements to ensure information is gathered and accurate records kept of safeguarding children training in order to provide assurance that all staff are suitably trained.
- The Trust should review the arrangements for audits of all medication stores to ensure expired medications are removed. Community staff should be reminded to check that medication is within date at the point of use.
- The Trust should ensure that collaborative working and sharing of information takes place between the specialist community palliative care team in Portsmouth and the community palliative care team in Southampton.
- The Trust should review the arrangments for peer review of practice for independent prescriber nursing staff.
- The Trust should develop the service in the Southampton locality to provide a falls exercise service as recommended by National Institute for Health and Care Excellence (NICE) guidelines
- The Trust should review the mandatory staff training programme to ensure adequate dementia training for all staff.

Action the community health service COULD take to improve

- The Trust could consult with commissioners to assess the local need for some services not currently commissioned, for example, a children's continence advisory service.
- The Trust could consider the staffing capacity of the health visitor service against demand in order to deliver the "Healthy Child Programme" outcomes effectively.
- The Trust could review the service provided the 'single point of access' telephone call centre, to ensure people receive accurate information about sexual health services.
- The Trust could review caseload turnover of community matrons to ensure effective use of their skills and timely delegation of the care of patients to other community nurse teams.
- The Trust could review the turnover of patients in cardiac rehabilitation clinics to ensure effective use of the specialist assessment clinics and progress of patients onto longer term maintenance support.

Good practice

Our inspection team highlighted the following areas of good practice:

- Across the Trust's services, staff demonstrated excellent commitment to providing the best care they could and putting the patient at the centre of their care.
- There was a positive working culture, demonstrated by staff talking with pride in working for the Trust and patients praising staff for their caring, compassion and dedication.
- We found many examples of very good integrated rehabilitation, supported by efficient multi-disciplinary teams working closely together to ensure the best outcomes for patients.
- The Children's Outreach Assessment and Support Team ("COAST") provides an excellent level of care and support to babies and young children at home with acute illnesses, and their families. We found this service to be both innovative and responsive to meet the needs of the local population, as well as supporting children through a short period of illness in their own home without the need for hospital admission. In addition members of the COAST team were working with the local acute trust to support the discharge process and enabling babies and young children to return home as soon as practicably possible.

Summary of findings

- Community dental services provide an excellent service to patients, children and young people with special needs.
- The Homeless Healthcare Team provides an excellent multi-disciplinary services to homeless people in Southampton. This provides a service designed to be accessible to this vulnerable group of patients and gives care and treatment to enable management of their long term conditions such as diabetes. The service promotes access by enabling people without an address to arrange appointments for secondary health care.
- The Specialist Community Pallative Care Team run an innovative clinic called "Key Transitions". This enables patients to attend through GP identification or by self referral. The service promotes early intervention on to the palliative care pathway.
- Staff across the Trust demonstrated a clear understanding of the organisation's vision and values, and these were well-embedded in practice.

Adelaide Health Centre

Detailed Findings

Services we looked at:
Community services for children and families; Community services for adults with long-term conditions; End-of-life care; Sexual health services; Community dental services.

Our inspection team

Our inspection team was led by:

Chair: Stephen Dalton, Chief Executive Mental Health Network, NHS Confederation

Head of Inspection: Anne Davis, Care Quality Commission

The teams included CQC inspectors, a variety of specialists and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Specialists included: school nurse, health visitor, specialist dentist, GP, sexual health specialist, children's nurse, older people's nurse, occupational therapist, speech and language therapists (adults and children), physiotherapist, palliative care doctor and community matron.

Background to Adelaide Health Centre

Solent NHS trust provides community and specialist healthcare services to a population of over a million people living in Southampton, Portsmouth, South East and South West Hampshire. Some services extend across the whole of Hampshire, including sexual health services and community dentists.

Southampton and Portsmouth each cover a relatively small urban geographic area and have a population of around 200,000 people with significant health inequalities. Hampshire covers a wider geographical area which is predominantly more rural and affluent and the health profile indicates in general a level of deprivation which is significantly better than the England average. There are three areas where deprivation is significantly worse than the England average: Havant County District, Portsmouth Unitary Authority and Southampton Unitary Authority. In Portsmouth twenty of the thirty two health indicators are significantly worse than the England average and in Southampton fifteen are significantly worse.

The trust provides a wide range of community health services, including community nursing, specialist community teams, specialist nurses and GPs, physiotherapy, speech and language, health visiting, school nursing and community paediatrics. Many services are provided through integrated multidisciplinary teams, providing care and treatment in community settings rather than in acute hospital. These include rehabilitation and re-ablement teams for or those supporting patients with specific conditions such as stroke and neurological conditions. Services are provided from over 120 different

locations including community and day hospitals, as well as outpatient and other settings within the community such as health centres, children's centres and service users homes.

The models of delivery of services varies across the two cities as a result of historical and commissioning differences. For example specialist clinics for long term conditions are directly provided by the trust in the Southampton area but not in Portsmouth, where provided by the NHS acute trust. Solent NHS trust provides specialist community end of life care services in Portsmouth whereas in Southampton the specialist palliative care team is provided by the NHS acute trust.

Why we carried out this inspection

This provider and location were inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

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

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

We carried out an announced visit 18,19, 20 and 21 March. Before visiting, we reviewed a range of information we hold about the community and mental health services health service and asked other organisations to share what they knew about the provider. The week prior to our visit we held listening events where patients and members of the public shared their views and experiences of services.

During our visit we held focus groups with a range of staff across community services (service leads, district nurses, community matrons, health visitors, community dentists and dental nurses, sexual health doctors and nurses, school nurses, specialist children's nurses, health visitors, health care support workers, allied health professionals- both adults and children). We observed how people were being cared for and talked with carers and/or family members, in person or on the phone, and reviewed personal care or treatment records of patients. We visited health centres, community clinics and accompanied staff on patient home visits.

We carried out unannounced visits on the evening of 20 March 2014 to Southampton Children's Outreach Assessment and Support Team (COAST), Portsmouth district nursing out of hours team and Southampton rapid response team.

Community services for children and families

Information about the service

Solent NHS Trust was first registered on 31 March 2011 and delivers community based services to children and young people, and their parents, across Portsmouth, Southampton and Hampshire. Services include health visitors, school nurses, community therapists, community paediatric medical -neuro disability, continuing care and children's nurses. The trust also provides services for Looked After Children.

The inspection team included an expert by experience, a health visitor, a school nurse, a children's community nurse and a community therapist. We attended a variety of clinics in different community settings, as well as accompanying staff on home visits to children and parents. We spoke with a variety of staff across the service including staff group interviews, focus groups, met clinical leads and carried out announced and unannounced visits to the teams. During our inspection, we spoke with approximately 30 parents and 50 staff. We looked at individual plans of care for children, risk assessments and a variety of team specific and service based documents and plans. We also sought feedback from external partner organisations.

Summary of findings

We found that the children's and families' service was safe, effective, caring and in the main responsive to the needs of the local population.

Services are generally safe. There were arrangements in place to minimise risks to children and young people receiving care and staff working alone in the community. Staffing levels were generally safe in the services and there was consistency in incident reporting practice. There were effective systems in place to learn from incidents and sharing of that learning both within individual teams and across the organisation We were told by staff that there were some inconsistencies in the recording of training.

Services were generally effective, evidence based and focussed on the needs of children and young people. We saw some examples of very good collaborative work and innovative practice. The trust was making changes to ensure the different parts of the service worked together to provide an effective service across the region. The majority of services' governance arrangements ensured a robust process of information sharing between operational services and the trust Board. Most teams had a clear overview of their own performance and outcome measures which were based on the needs of the population.

The vast majority of people told us they had positive experiences of care. Parents and carers felt well supported and involved with their children's treatment and told us that staff displayed compassion, kindness and respect at all times. Many staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to people and their representatives and the values of the organisation they worked for.

We found the children and families service was responsive to people's needs and people from all communities could access services. Overall we found that effective systems were in place to ensure that children, their relatives and those close to them received the support they needed in the community, despite some differences in local commissioning arrangements.

Community services for children and families

The service was in general well–led with effective decision making and strategic planning. There were risk management systems in place across the service and generally staff had a clear oversight of risks to quality in the organisation. Innovation was encouraged by the leadership of the service and this led to improvements in the delivery of services.

Are community services for children and families safe?

(for example, treatment is effective)

Safety in the past

For the Children's and Families Service, overall we found that care had been safe in the past. This was generally supported in all areas we inspected where we found that systems were in place that protected people from abuse and avoidable harm, supported staff out of hours, and provided guidance in cases of emergency, including individual staff responsibilities. Staff were clear and positive about reporting incidents and the service demonstrated high rates of incident reporting. Staff told us that there was good interagency working to keep children and young people safe. The service completes a monthly Quality and Risk Report for children's services which provides an effective overview of the level of incidents and concerns.

Learning and improvement

We found that there were systems in place, with appropriate information cascaded to staff relating to child protection planning, investigations and outcomes of safeguarding concerns. We also saw that learning from concerns, including serious case reviews, was embedded across teams and staff were supported by the provider's Safeguarding Children Team. This included the provision of advice for urgent concerns and via providing safeguarding supervision sessions for staff. We found that shared learning from concerns was incorporated into ongoing training and development events across all service areas. The safeguarding children's team had an effective system in place for auditing the service and produced an action plan to summarise the level of risk and target dates for completion of any required actions. It included staff feedback on the effectiveness of safeguarding children's training. For example, in quarter 3 in 2013, 84% of staff felt that the training would improve their working practice.

Systems, processes and practices

The provider had policies and processes in place regarding incident reporting and these were available for staff to refer to. Staff understood safeguarding reporting protocols and we found that concerns were appropriately recorded and reported. Lone working policies were in place and staff followed them. Staff told us they had received appropriate

safeguarding children training but we were told that training records were not accurate or complete. This meant there was not a current, comprehensive overview of the entire workforce's safeguarding children training.

The locations we visited were fit for purpose and the service had effective infection control procedures in place. Medicines, including first aid boxes, were kept secure and handled safely. Equipment was well maintained so it was safe for use. Concerns about the connectivity and access to IT systems were reported by a number of teams as it affected work performance significantly at times. The capacity of the Child and Adolescent Mental Health Service ("CAMHS") could have been increased if effective IT systems were in place.

Recording was generally effective but for the health visitor service, we found that due to high demand and staff capacity issues, not all relevant information had been recorded in the children's "Red Book" health visitor records. This meant that essential information, whilst recorded on the provider's IT systems, was not always documented on the child's own Red Book.

Monitoring safety and responding to risk

Overall we found that systems were in place to monitor and respond to risk. We found staffing levels and skills mix supported safe practice in all the areas we inspected. Risk assessments had been conducted to ensure staff and patient safety. Due to the demand and capacity of the service, some teams told us that they were stretched at times of acute need, but this did not compromise children and young people's safety. We saw management plans were in place to address these concerns and that staff had appropriate support mechanisms in place. The children and families services staff were clear of the systems in place to monitor and escalate risks. We found that areas of risk were reported to the Board via the corporate risk register.

The lack of capacity of paediatricians in the Looked After Children's ("LAC") service was affecting the outcomes delivered for children and young people as not all new assessments and reviews of care needs were carried out within the trust's target timescales. This concern had been escalated to the Board but the staff we spoke were not able to tell us what the resolution plans were. The children's end of life care team was providing an effective service, and visited out of hours if required. But a 24 hour on-call service was not commissioned and this concern had been escalated to the board. The parents we spoke with were aware of support systems in place should they wish to report concerns.

Anticipation and planning

In relation to safety in the future we found that the trust had systems in place to deliver safe care both now and in the future. The impact of various teams' restructuring processes was being evaluated with consideration of staffing capacity and the level of service that was commissioned. The provider was assisting partner organisations to set up a children's Multi Agency Safeguarding Hub ("MASH") in Southampton. The impact on the service and its ability to provide staffing cover for the MASH was being assessed. The Portsmouth area had a Joint Action team ("JAT") to facilitate effective interagency working regarding urgent safeguarding concerns. Information and learning from serious incidents and safeguarding concerns was being used to provide the Board assurance that good, safe care was provided within all its services, both currently and in the future.

Are community services for children and families effective?

Evidence-based guidance

Overall we found that the care provided was evidence based and followed recognised and approved national guidance. This was evidenced in all areas we inspected where we found staff were clear of their roles in care pathways. Staff worked well with multi-disciplinary colleagues to ensure optimum health and well-being of children and young people. They involved their parents in planning their care, including consent and they followed national guidance on consent for children assessed as competent. For example, the Children's Outreach Assessment and Support Team ("COAST") had developed clinical pathways for ten medical conditions using the National Institute for Clinical Excellence ("NICE") guidance. They had engaged with local GP surgeries so the referral process for children and their families was clear, effective and timely.

Monitoring and improvement of outcomes

Overall we found that arrangements were in place to monitor performance and to identify areas in need of improvement. This was generally supported in all areas we

inspected where governance arrangements ensured a robust process of information sharing between operational services and the Board. Information provided to the Board included: quality and safety reports with performance and delivery against key performance indicators; outcomes of clinical audit activity; and patient experience information, including trends identified following review of such information. For example, the Child Development Centre was seeing all children and young people within referral and assessment timescales. They were undertaking work to analyse the reasons where children and young people did not turn up for appointments.

The continuing care team provided effective complex nursing care packages for children at home and at school. They told us that requests for changes to the existing package of care were processed quickly and effectively so that the changing needs of the children were met appropriately. For example, the COAST team were monitoring activity on an ongoing basis and evaluating outcomes of actions taken by the team. The evaluation was incorporated within individual clinical supervision and used as points of learning.

Staffing, equipment and facilities

Overall we found that there were systems and processes in place to identify and plan for children and young people's safety issues in advance. This was generally supported in all areas we inspected. We found risk assessments being used to determine staffing requirements, comprehensive inductions for new staff, effective appraisal processes, clinical supervision arrangements and good access to and attendance at mandatory training.

The school nursing service was delivering the Healthy Child Programme (HCP) programme effectively and meeting all its commissioned outcomes. However, the Health Visitor service, was not meeting all HCP targets. "Building Community Capacity" work was limited and variable as staff reported that their caseloads were currently large. The management arrangements across teams was generally effective and supportive but some teams' managerial capacity was stretched as they oversaw a number of different physical locations. Equipment and facilities were generally fit for purpose and provision across the whole region served by the provider had been made. Some delays in the provision of individually adapted mobility equipment were identified and this was in part due to the change in commissioning arrangements for this service. Staff also told us about IT issues regarding remote working and in some cases staff had to duplicate information across hard copies and electronic records risking information being lost.

Multi-disciplinary working and support

Overall we found good collaborative working within the multi-disciplinary team ("MDT"). This was supported in all areas we inspected. We found: staff worked well together; effective communication between staff; healthcare professionals valued and respected each other's contribution into the planning and delivery of children and young people's care. This work was underpinned by sound implementation of approved care pathways, for example, within the COAST team. There were clear plans on what to do if support needed out of hours when COAST was not operating.

We found that the trust was committed to ensuring the care of children and young people was delivered as close to home as possible, minimising disruption to their daily life. This was supported in all areas we inspected where we found services provided from clinics held throughout the geographical patch and good multi-professional staff engagement. This ensured the delivery of care met children and young people's, and their families, needs both from a clinical perspective and also close to home. The children's community therapies service, including speech and language therapy ("SALT"), physiotherapy and occupational therapy, demonstrated effective interagency working with robust planning and delivery of commissioned outcomes, coupled with clear strategies for change management.

Moving between services

Generally transition arrangements were effective across services with appropriate referrals and with the provision of key information. A lack of capacity in the CAMHS service caused by a high demand in urgent crisis work meant that there were some delays in accessing the service but an effective triage procedure was in place to focus capacity to those most at risk. Some delays were reported in referrals to social services due to the capacity and demand on the local authority.

Community services for children and families

Are community services for children and families caring?

Compassion, dignity and respect.

We found the care and treatment of children and support for their families, within all services was flexible, empathetic, and compassionate. Staff across the service promoted and maintained the dignity of all children, their parents and representatives. Each child and family's culture, beliefs and values had been taken into account in the planning and delivery of care. Staff ensured confidentiality was maintained when attending to care needs. We found that staff had developed trusting relationships with parents and representatives that focussed on maximising children's and young people's independence.

We saw that feedback from children and their families had been sought regularly by the service. In all the responses we looked at, feedback was very positive and evidenced the compassionate approach by staff to ensure the service they delivered was focussed on the children. We saw that generally parents' expectations of the service had been met.

We spoke with some external agencies that supported children using services provided by the Trust and they gave positive feedback about the effective working relationships with staff and how individual outcomes for children were set and met. They told us that staff were flexible, responsive and effective in meeting the needs of the children and young people.

Informed decisions

We found that staff delivered child centred care within all it's services and that children, their parents and carers were involved in and central to all decisions made about the care and support needed. Overall we found that parents had an understanding of their children's care and treatment that the service provided. This was supported in all areas we inspected. Through observation of practice and review of records, We found robust evidence of actions taken by staff to ensure parents understood what was going to happen and why, at each stage of their child's treatment and care. This included adapting the style and approach to meet the needs of individual children and involving their relatives in all the services and settings we visited. For example, the COAST team care plans that we saw included information for parents about the condition, care and treatment of their child but also signs of deterioration to watch for and what to do.

Emotional support

We found that the trust delivered good emotional support within all its children and family services. The parents we spoke with told us that there was effective communication from staff and that any concerns were addressed quickly and appropriately. Guidance was available for parents about a range of support services if required. Care plans gave guidance for staff in supporting families and were focussed on the children and maximising their independence. Staff also told us that they generally felt very well supported and cared for by their managers and we saw effective systems for staff one to one supervision and peer group support were in place.

Are community services for children and families responsive to people's needs? (for example, to feedback?)

Meeting people's needs

We found that the service delivered individualised and child centred care. This was generally supported in all areas we inspected. We found multi-disciplinary professionals worked flexibly to ensure joint approaches to care delivery to combine the meeting of identified needs of children with minimal disruption to family routine.

There were arrangements in place so that the service informed commissioners of the local needs of the population. The service's contribution to the Southampton MASH and Portsmouth JAT supported multi-agency partnership working to keep children of the local community safe. We found that the geographical location of the service could affect the parameters of the service being delivered, due to different commissioning arrangements in place but the needs of the local population were being met.

Access to services

We found that access to the majority of services was good. This was generally supported in all areas we inspected. We found that 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. For

example the health visitor service arranged drop in clinics for children and families from ethnic groups which led to increased attendance and engagement from the population. However, effective consultation across all sectors of the population was variable. We saw that the LAC service had creative initiatives to meet the needs of adolescent users of services, designed to facilitate their effective engagement with professionals. We also saw teams had information available to parents regarding access to other services, for example from the local authority.

Care co-ordination

We found that the community children's services delivered good safe care co-ordination within all its services. This was generally supported in all areas we inspected where we found that care arrangements met the needs of children and their parents. We found effective communication between community multidisciplinary teams and partner organisations to focus care and treatment on the needs of children using the service. We saw effective liaison between therapists and community nurses so that effective care and treatment for children was designed to meet their needs. We saw that the SALT service had an effective process for peer reviewing clinical decisions to ensure high quality care and treatment was provided to children using the service.

Learning from experiences, concerns and complaints

We found that the service had systems in place within all its teams for learning from experiences, concerns and complaints, and that these systems were generally effective in all areas we inspected. The responses and feedback from parents of children using the service were collated into a monthly quality and risk report for the service. Concerns and themes emerging from parents' feedback were shared with staff and used to further develop and enhance the service. We saw that children in both primary and secondary school designed the feedback forms for the school nursing service. Feedback was then evaluated and passed to commissioners and schools. We saw that access hours to some clinics had been changed to reflect feedback from parents. Staff we spoke to considered the trust did listen to and respond to their feedback.

Are community services for children and families well-led?

Vision and strategy

The service generally had clear and focussed management at team level that gave staff a clear direction of travel to develop the services further so that the needs of children using the service were met. Most teams felt that there was a forward plan for their service. We saw that some teams had undergone a restructuring process, such as the Children's Community Nurses, to ensure a consistent and flexible service was delivered. Some teams felt more work was required to redesign their service to meet the needs of the population and that effective liaison with commissioners was required. Staff generally felt able to contribute to this process so that their voice was heard to represent the needs of the children using the service. The service has an Integrated Business Plan, which sets out the plans for services for children, and their parents, in the context of the Trust's strategic objectives. These focus on admission to hospital avoidance and single point of referral for children and young people and the expansion of services to the wider geography in Hampshire and West Sussex. Staff were aware of the trust values, corporate objectives and the trust's quality wheel, which was a key statement of the trust's values and behaviours.

Governance arrangements

We found generally that the service had effective process in place for carrying out clinical audits and that any actions required to resolve concerns were taken. The service contributed to the operations governance group and practice development groups. We found that there was a proactive development committee that involved staff sub groups who were able to feedback people's experiences. This supported effective practice development for the service, linking activities to effective outcomes for children and their families using the service. The service maintained a risk register that then fed into the corporate risk register so that the Board had oversight of the main areas of risk for the service.

Leadership and culture

We saw effective leadership at team level and staff told us they generally were well supported by their managers. We saw effective processes were in place to support front line staff via effective supervision, appraisals and ongoing training and development. The service monitored the

impact of lone and out of hours working for staff and sought to promote the wellbeing of staff via a range of team and service support mechanisms. Staff were encouraged to be innovative and we saw that the Southampton area school nursing service had won the Trust's "Dragon's Den" scheme and were awaiting the purchase of an ambulance. This would enable them to access the community more effectively and to take the school nursing service to schools and community centres.

Acting on feedback

Patient experience reports were reviewed by the Board monthly. This report included an update on actions to date relating to issues raised from internal audits, patient surveys and complaints. The report outlined individual complaints and how they were dealt with and the key learnings to be shared with staff. We saw strong partnerships within services provided to children and their parents and the service demonstrated effective multi-agency working to focus the service on the needs of the children using the service.

Continuous improvement and innovation

The vast majority of staff had completed mandatory training and considered the organisation to be supportive of new initiatives. We found several examples of service led innovation, for example the COAST service. Also a school nurse had been nominated for an award by the Nursing and Midwifery Council for the creation of an "absence booklet" which addressed one of the government's health and educational targets to increase attendance at schools.

There were systems for identifying and investigating safety incidents and an emphasis in the organisation to reduce harm. We saw consistent systems in regards to safeguarding practices, including prioritisation of training and awareness of appropriate escalation process for those working alone in the community who may observe safeguarding concerns. There was appropriate monitoring, reporting and learning from incidents. We saw clear and effective management across the teams in the service. IT challenges were widely acknowledged for staff working across all teams and we found that plans were in place to address these issues for these staff members.

Community services for adults with long-term conditions

Information about the service

People with long term conditions received services from a range of clinical professionals and support staff in their own home and through attendance at community based clinics. Trust staff cared for patients who needed treatment, rehabilitation and care through a pathway of support from acute illness, such as after a stroke or other neurological injury. Clinical advice, treatment and monitoring were provided by consultant physicians, general practitioners, therapists and nurses and other care staff in multidisciplinary teams. The provision of treatment and care for long term conditions covered a wide range of the trust activity from inpatient units to several teams in the community and including some primary care services.

Community services that we inspected included

- community nurse teams
- community matrons
- rapid response teams who work to reduce the need for hospital admission
- specialist rehabilitation teams including for cardiac care, stroke, and other neurological injury.
- rehabilitation and reablement team
- specialist clinics such as cardiac rehabilitation and drop in clinic for homeless people
- therapy staff based at inpatient services

Our inspection

The inspection team included three compliance inspectors, general practitioner, occupational therapist, community matron, speech and language therapist and three experts by experience.

During the inspection we spoke with patients, relatives or carers, and observed services being provided.

We visited specialist clinics, community service bases for rehabilitation, and community nursing teams. We interviewed over … staff across different teams including medical and nursing specialists, and dedicated teams such as those providing support or rehabilitation for people who had a suffered a stroke, or had cardiac or respiratory disease.

Summary of findings

Overall we found that because community teams provided a coordinated and comprehensive service, people with long term conditions received safe care. There was good communication between inpatient locations and community services which meant that people were supported effectively to improve or maintain their health and welfare and reduce the need to return to hospital. There were clear examples of effective multidisciplinary working across teams and with other organisations. There were excellent services that improved health and wellbeing for vulnerable people such as the homeless. We saw examples of how the services promote safe care by monitoring and learning from incidents, and using a range of benchmarking activity comparing against national and regional performance. Teams and specialist practitioners worked within accepted research based guidelines.

We were concerned about safety of patients being supported by some of the community based teams. This was due to staff deployment, especially out of hours, not matching demand in some localities. This had been identified by the trust as a risk but had not been fully resolved although staff had been recruited for some teams. To monitor the risk the trust had a system whereby staff levels were reported to the senior nurse each day.

Services were effective as staff worked in a robust multidisciplinary way that meant patients were supported through the phases of their illness and to remain at home. There were many examples of good liaison with hospitals or inpatient units to promote early discharge or to prevent hospital admission. There was effective monitoring of the performance of teams to support people with long term conditions through reporting within teams and to the trust managers. There were specialist nurses, and therapists who provided expert advice across teams. Consultant medical staff or general practitioners led some areas of the service such as clinics and community virtual wards which meant that medical decisions could be made along with the multidisciplinary clinical team

Community services for adults with long-term conditions

Services for people with long term conditions were caring. In our discussions with patients and relatives or carer people were mostly very satisfied with the care and support they received. Patients receiving rehabilitation and ongoing care described being well supported by a team of staff who recognised their needs and agreed plans of support with them. We observed staff providing compassionate care and consulting with patients in clinics and in their homes. In several teams we saw that patients were allocated a key worker with whom they could build a trusting relationship and who ensured wider needs were met to promote health and welfare.

The staff in community and inpatient services of the trust worked in multidisciplinary teams and collaboratively with patients to provide care and treatment that met patient's needs. This enabled people to stay at home as they managed living with long term conditions or to recover from acute phases of their condition. Specialist clinics in community locations had been established by the trust where staff provided expert advice at appointments or rehabilitation sessions. There was an excellent drop in centre catering for homeless people who could receive support for long term health issues such as diabetes and including screening for liver disease. People with rheumatoid arthritis were supported to sample exercise or relaxation sessions that may be of help to their condition and also encourage social interaction.

Services were well led because the trust had developed a clear strategy to support people long term conditions. Managers and staff had been restructured in a way that promoted integration of services for those patients living with long term conditions or receiving rehabilitation to improve their health and welfare after injury or acute episodes. Needs assessment in the area covered by the trust had shown that increasingly people will have multiple health needs. To manage this the trust had developed teams that included a range of specialists to work in a multidisciplinary way and to enable complex case management. The trust had established central points of access and clinics for people needing care, treatment and advice about their conditions. Staff said they were able to openly discuss any issues about patient care and safety with their managers. Staff told us they were supported to develop skills and knowledge and continue to develop their professional competencies to support the complex needs of patients they cared for.

Community services for adults with long-term conditions

Are community services for adults with long-term conditions safe?

Services were generally safe. Arrangements were in place to minimise risks to patients including staff awareness of safeguarding procedures. Incidents and performance of services were reported and issues were investigated, lessons learnt and the results fed back to staff. Staffing levels were generally appropriate to the needs of the patients but in some community nursing teams there had been staff shortages especially out of hours.

The trust had investigated and informed staff about an incident in which out of date injections had been used five times before the expiry date had been noticed. We found expired medications in storage at a community base which were removed once this had been identified.

Safety in the past

Teams were established to reduce hospital admission and promote early discharge to ensure timely and safe transfers of care. This was effected by providing multidisciplinary care in the community by clinical staff with specialist knowledge to promote safety of people with complex needs. This included assessment of risks and monitoring of health conditions. This support was provided by teams such as district nurses, rapid response teams, specialist stroke care teams and community based specialist clinics. We saw that some teams had specific pathways that were agreed with other service providers regarding the management of patients from hospital to community and this helped to clarify responsibilities for all staff and teams. This meant that people were cared for by teams with specialist skills, and systems were in place in the community to promote safety of people with complex conditions.

Staff were aware of the safeguarding policy and procedures and told us they would report to managers or the local safeguarding authority where they had concerns about the possibility of abuse. Staff in different teams told us how they had identified issues in a care home, in people's homes and when assessing patients in clinic and how they had referred issues to the local safeguarding authority for investigation. Staff also described their awareness of their responsibilities under the Mental Capacity Act 2005 (MCA).

Staff showed us the systems for reporting untoward incidents and we saw there were reporting systems for falls, and pressure ulcers as part of monthly performance monitoring. The trust's rate for new pressure ulcers was above the national average, but it was following the England trend of a general decrease in new pressure ulcers and most of the reported cases occurred in the community where staff did not monitor patients continually. To monitor this more closely the trust required staff to report all pressure ulcers of Grade 2 or higher and had introduced processes for reviewing all incidents to identify if they may have been avoided. The trusts rate for falls with harm was above the England average for most of the previous 12 months, but had started to reduce.

Learning and improvement

We found examples of how the trust had responded to risks to improve safety and welfare of patients. We saw that community teams had recorded near misses and these were reviewed monthly to learn lessons. We found that the homeless team had reviewed near misses in order to promote future safety for vulnerable patients attending the drop in clinics. The organisation has established safety related goals for example when community nursing teams reported low productivity and the inability to provide contemporaneous entries in care records the trust responded by providing additional computers

The trust had reported comparatively high incidence of pressure ulcers last year. We saw that an audit had been carried out by the tissue viability nurse in August 2013. The report shared with community teams and actions were taken such as additional training across the localities. New forms and guidelines were designed to support accurate grading of pressure ulcers. A new specialist camera was procured especially for photographing wounds to show depth and perspective. New wound products and equipment were tested and checked prior to being able to be used by the Trust. This meant that the trust had responded to the risk issues by improving staff competencies and resources.

The trust had established a falls case coordinator post which enabled people who had been identified in the community by ambulance personnel as having had or being at risk of a fall but not taken to hospital. The service was preventing further risk and injury to people through advice education and referral for additional support such as occupational therapy or equipment. Initially the coordinator saw patients who had been taken to hospital but the trust have learnt as the service developed. We

found that the service had improved the effectiveness by targeting those people not getting support after an ambulance visit to their home. The service was reducing the need for people to make emergency department visits and hospital admissions.

Systems, processes and practices

We found there were systems and processes in place to maintain patient safety. There were specialist nurses leading services and clinics and within community teams. This meant that people with long term conditions were triaged and assessed accurately so that safe treatment and care was provided to guard against risks associated with their complex condition.

Staff told us they were clear about the incident reporting mechanism and that they attended serious incident panel if required to help with learning from the case and felt they got feedback from incidents that had been investigated. The rapid response team (RRT) which provides support to prevent hospital admission and facilitate discharge included consultant in medicine for elderly and other senior medical staff to ensure patients receive appropriate medical care alongside nursing, therapy and social care. We saw that all patients had their cases reviewed weekly. There was a social worker within the RRT and staff told us that there was good communication between RRT and patients GPs and social services teams.

We were concerned about staffing levels in some locality based community nursing teams. We found there were risks to safety of patients being supported by the community based teams due to insufficient staffing or deployment. We interviewed staff and discussed examples of near misses. Staff felt there were some localities where the community team did not match the local demand due to the size of the primary care practice, and this particularly caused problems for out of hours periods. We found that patients requiring insulin may be sometimes be having their evening injection too early due to community nursing staff shift end times, or too late where the evening cover rapid response team become responsible but could not attend at the time that the patient needed their injection. Resourcing and demand on the rapid response team had been identified by the trust as a risk to patients but had not been fully resolved.

We checked medication in a storage area of the rapid response team and found there were out of date supplies. The staff rectified this quickly but this meant that systems were not effective in ensuring safe storage and turnover of medication.

Systems to maintain and service equipment were not effective. We examined equipment in different community bases and clinics and were not able to verify that items had been serviced at the appropriate dates. Staff could not verify that some diagnostic equipment such as weighing scales had been calibrated.

We saw that staff had completed training about infection control and were able to tell us about precautions taken to prevent and control the spread of infection. We examined patient's care records and found that falls risk assessments and specialist prevention plans had been fully completed. Documents also included where needed a post fall guidance protocol for staff or carers to follow. Staff in different community teams were aware of lone working policies to protect the welfare of staff.

We saw that patient's records were held on a variety of paper or electronic systems. This meant that community nurses and matrons sometimes had to spend additional time transferring information from paper to computer records and systems were not always compatible with other local health services. The need to record all activity on the IT system meant that patient notes were not always available in their home. Community nursing staff told us that visits were written up upon return to the office which could lead to inconsistency in record keeping. We found there were shared notes in the home but these were not always used by all member of the multidisciplinary team. This meant there was the potential of unsafe care as staff may not always have information to hand about previous actions or assessment by other staff.

Monitoring safety and responding to risk

We found that all teams in the community were aware of key risks such as falls in people who were less able due to long term conditions or during rehabilitation. We saw that falls risk assessments were completed and staff responded to findings by referring people for additional assessment from falls specialist or for relevant equipment.

Staff told us that when they were supporting people at home they worked closely with families and carers where needed on issues such a manual handling to maintain

safety for patients and carers. Where needed the staff had also referred carers for support from a back care advisor. We observed safe patient handover led by a case coordinator. The senior nurse provided a clear clinical overview and identified key issues for the next shift to be aware of.

Staff told us that in some community teams there had been vacancies that meant many staff had been working over their contracted hours. We found the vacancies had been filled and teams were now usually able to meet the demand for patient referrals. The trust had responded to information about incidents occurring and staff views by recruiting additional staff.

Anticipation and planning

There was effective planning of patient care and treatment and the patient pathway through multidisciplinary team (MDT) meetings where individual cases were discussed. We observed neurological team MDT session at which very detailed planning was discussed to ensure patients were discharged safely. Teams in the community covering virtual wards had MDT meetings led by senior medical staff to plan continuing care of patients at home. Specialist clinical nurses were included in meetings where appropriate and supported the planning of ongoing care of patients using accepted guidelines and pathways.

We saw that therapy patient notes included alert notices where the patient required more than one person to attend for example when there was a risk of falling. This protected the safety and wellbeing of patients and staff. We observed in one clinic that three staff were attending one person to ensure safety and prevent a fall during rehabilitation exercise sessions.

Staff told us that the Rapid Response Team (RRT) was the nursing service that provided the out of hours service to the older population in the community in Southampton. Staff felt that some of the workload did not require rapid response but a regular community nursing service. There were capacity issues partly due to this arrangement which meant that the service stopped accepting patients for rapid response on some occasions. Although these issues had been identified in the risk register for the trust, staff felt that problems had not been resolved. In the Portsmouth Rehabilitation and Reablement Team (PRRT) staff showed us the display of capacity and demand which was updated daily. Information on capacity to manage cases was also shared with the hospital to promote safe hospital discharge.

We found that some clinic staff were unsure as to the procedure for resuscitation but relied on a GP being available from another part of the building, however most staff we spoke with had attended mandatory training which included how to manage patient emergencies such as collapse.

Are community services for adults with long-term conditions effective?
(for example, treatment is effective)

Services were effective. We found that care pathways and service arrangements were evidence based and met the needs of patients with long term conditions. There were strong examples of well managed multidisciplinary working to ensure patients received timely and accurate care and treatment. Staff were deployed appropriately and teams had a good skill mix with specialist support where required. In some localities it was not clear that patients were discharged from community matron caseloads, or cardiac rehabilitation clinics when the specialist support was no longer required.

Evidence-based guidance

Teams across the community service used National Institute for Health and Care (NICE) guidelines in managing patient pathways when people had long term conditions such as diabetes or recovering from a stroke. We saw that this was the case for virtual ward community nursing staff alongside the specialist rehabilitation at home staff. Risk assessments in care records reflected NICE guidelines in practice including pressure ulcer risk and nutritional assessment and falls assessment. In some localities there was a lack of exercise provision in the falls programme which meant the NICE falls guidance could not be followed for patients in Southampton.

We spoke with a tissue viability specialist nurse who provided training to ensure competency of colleagues who run leg ulcer clinics. Staff use specific wound dressings only used clinical evidence shows a product is effective.

Staff were aware of their responsibilities regarding mental capacity and consent. We spoke with care staff who also

understood the need to gain consent, and about patient's variable capacity. Staff said they would refer to more senior clinical staff if they were in doubt about a patient's understanding or co-operation with treatment plans.

Cardiac and respiratory clinics were using NICE guidelines. We found the cardiac rehabilitation service covering the Southampton and West Hampshire area was effective. There were five clinics held across the area. The trust was establishing an additional GP with special interest post and administration support to enable the trust to meet the local needs for the clinics. Staff told us that cardiac rehabilitation courses were well attended and completion of courses by patients was high.

All therapy teams used the standard of 45 minutes of therapy daily for patients on an initial rehabilitation programme; this was adhered to in the inpatient rehabilitation units we visited and the community teams. Community stroke teams provided a six week programme of support; an established level that has been shown to provide the best outcomes for people's rehabilitation. Staff in different teams told us that the period of support to patients on rehabilitation was flexible and not time limited. This meant that people could receive continued support and encouragement to meet their agreed goals and could include emotional support which may require a longer period of support

Monitoring and improvement of outcomes

We saw evidence that community teams monitored the performance of their treatment and care. In one community base we saw up to date monitoring charts so that all staff could see if there had been good use of staff resources, any incidents or complaints and overall patient satisfaction. Additional meetings with patient groups were established to provide support for problems arising from their conditions, for example therapists provided a fatigue management group to support people with multiple sclerosis in dealing with this symptom.

There were records of clinical audits checking that nutrition assessments and falls audit, and non clinical audit of care records were completed. We examined audit records that showed the trust participated in the safety thermometer national audit. The results show high incidence of pressure ulcers but low incidences of infections related to urinary catheters.

Staff told us that the rapid response team (RRT) met the target timescale to visit, assess and commence support once patients were accepted into the service. Daily performance reports were kept in the Portsmouth Rehabilitation and Reablement Team (PRRT) with feedback to staff on the team's performance. However there had been minimal monitoring of activity or outcome measurement for some localities of the RRT in the year prior to our inspection.

The rehabilitation services maintained a database of patients to enable long term monitoring and prompt annual review as needed. The trust had contributed data to the national Parkinson's disease audit. Neurological rehabilitation teams showed us a range of benchmarking activity they undertake which meant they compared their ways of working and patient outcomes with regional and national information. Staff said they had been able to visit other areas to gather ideas to improve services. A new patient information leaflet had been prepared as a result of this work. Staff had also attended specific training related to stroke care as recommended in the national strategy for this condition.

Staffing, equipment and facilities

Multidisciplinary teams established to support people with long term conditions in the community and inpatient units of the trust. These teams worked well to provide care and plan recovery for patients who had complex needs due to their condition or social situation. In different teams, inpatient or community we saw that patients were allocated a key worker from within the team who helped to coordinate care and treatment and to promote timely outcomes by liaising between staff or with other agencies. The trust had recent recruited more nurses after identifying a service need and this meant staff could receive appropriate professional supervision to maintain and develop skills.

Staff told us they received regular supervision. This allowed all staff to discuss their role, issues of caring for patients and plan their personal development. When we spoke with registered professionals such as nurses and therapists they told us there were clear systems to ensure they received appropriate professional supervision. Professional supervision is a requirement for continued registration by all professionals to maintain safe and effective practice. Some staff said their teams arranged peer or group supervision to discuss their practice. We saw that

organisational changes meant that some professionals, such as physiotherapists or occupational therapists, were managed by a person who was registered as a different professional. Staff told us that where this was the case the trust had supported a supervision system that enabled peer or senior professionals of the same type but from other organisations to help provide this essential role. Staff such as speech therapists and clinical psychologists also told us that the trust supported them to maintain professional skills and knowledge including through supervision arrangements.

We spoke with staff in the single point of access service. This was a central call facility for services across the trust. This includes healthcare professional referrals, direct health advice for patients with diabetes, messages for community nurses and appointments for some clinics. The service was handling a large number of calls every day which had reduced direct calls to professional teams and so improved their efficiency. Staff in the centre told us they were trained in all relevant areas and their mandatory training was kept up to date.

Community nursing staff told us there were different ways of team working in Portsmouth or Southampton. The collaboration between community matrons and district nurses was variable across teams as some share caseloads and other teams work separately. In view of different ways of working it was not clear that staff resources and systems were being deployed effectively, and staff may not be clear about their responsibilities to patients. We found that some community matrons had caseloads that were relatively static and that patients were not being delegated on as they recovered from needing specialist support. It was not clear how patients would be assessed as ready for discharge and so be cared for by district nurse or other teams. This overlap and lack of clarity over roles in some areas may be reducing the effectiveness of the use of resources.

We saw that many patients received extended periods of support and guidance at clinics and sessions for cardiac rehabilitation. Some patients had completed their course of rehabilitation but continued attending regular assessment sessions rather than moving on to longer term maintenance support. Although this meant staff were able to monitor their patient group in this way it may not have been the most effective use of specialist nursing staff time.

We found there was good use of information technology (IT) systems for the teams where it had been implemented. Mobile technology was used to enable staff to enter their care records of look up relevant patient information. In some teams however this had not been put in place. Staff told us that in part of the rapid response community team a patient's initial assessment was completed on paper, then later transferred to the IT system in the office. This meant that patients were left without clear up to date records in their home for other visiting professionals to refer to. This could pose a risk of delays in care, or repetition for the patient. Staff in some parts of the community and inpatient services told us they did not have enough computer terminals or mobile hardware to promote effective working.

Community staff told us of some delays in discharge from hospital due to initial problems with the new system of providing equipment to people in their homes. There were also examples of poor quality equipment being provided but staff told us that this had been quickly remedied by the equipment supply service

Multidisciplinary working and support

We found that community teams worked well in a multidisciplinary way by involving appropriate specialist nurse or therapy practitioners from within their teams or from other teams. We saw several examples of in-reach services in which practitioners visited patients in hospital to facilitate early and efficient discharge. The community stroke teams worked closely with care agencies who provide other personal care and home support. This promoted the continuation of rehabilitation activities by people providing support in addition to the visiting therapists. This meant that discharged patients were provided with coordinated, effective and safe care when they arrived back in their home setting.

Therapy staff worked well together to support people's rehabilitation. Although the different therapists had their own assessment and planning of the support for the patient we saw there were multidisciplinary discussions and also examples where therapists undertook joint sessions to ensure the patient understood the team approach to their rehabilitation. We saw that one patient with complicated needs had care and advice from occupational therapist, physiotherapist and clinical psychologist to manage some complex. We also spoke with patients who said they were referred between therapists as

issues were identified; one patient said they had been referred by their occupational therapist to a clinical psychologist. We saw that people receiving support from neurological rehabilitation teams had been referred for vocational support. This meant that people with long term conditions and those needing rehabilitation were supported by the service to meet a wide range of their needs and to access appropriate services.

Staff told us of the virtual ward model that had been implemented which included a consultant in medicine for the elderly, social worker, falls coordinator, community matron and other nursing and therapy staff. This was an effective system to ensure patients at home had coordinated care packages. There were weekly meetings which helped to focus staff around complex cases that had been admitted to the 'virtual ward'. We saw that clear patient outcomes and care plans were developed by the multidisciplinary team at the meeting.

Specialist nurses told us they worked with wards and community teams to share skills about managing wounds. In addition the nurses train local social services care staff and some staff in care homes in basic wound care, skin care, and appropriate use of pressure relieving equipment. This contact allowed issues to be identified rapidly with the specialist nurse being called out for advice as required. This was important for patients as the trust had a relatively high incidence of pressure ulcers when compared nationally.

Are community services for adults with long-term conditions caring?

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

Compassion, kindness, dignity and respect

We observed, in different clinics and groups, that specialist nurses and therapists had developed good relations with patients. This helped to relax patients and promoted their understanding and compliance with advice and treatment of their long term health conditions. We saw that staff in all situations talked with patients in a respectful way. We observed staff being supportive and encouraging during therapy exercise sessions which may have been difficult for the patients. In one clinic we observed staff helping someone understand how their core muscles were important for posture and balance and saw that staff were conscious of the persons dignity in the group. One person said in a patient feedback survey that rehabilitation support was caring and comforting which they felt promoted faster recovery.

In our observations of care in clinics and in people's homes we saw that staff patient interactions were positive and effective. Appropriate communication skills were used and caring and compassionate attitude was shown. We saw a patient with severe Alzheimer's' disease being treated with dignity and compassion. Staff were observed to be respectful. We saw that privacy and dignity and confidentiality were maintained.

We saw that in respiratory clinics the staff had good relations with patients. It was clear as we observed the clinic that staff were dedicated to patient's wellbeing and progress in their rehabilitation. We spoke with staff who were meeting people for clinics. The staff showed knowledge of the services the clinical team offered and were aware of treating patients as individuals and maintaining confidentiality.

We observed therapy staff providing exercise sessions in groups and individually to patients. We saw that staff were supportive and encouraging to patients, empathised with their difficulties, and promoted a positive attitude.

Informed decisions

Staff recorded goals for patients that were jointly agreed with the patient and the carer where appropriate. Managers told us that a key principle was to work in collaboration with patients on their rehabilitation. We saw this in the community and the inpatient services providing care for rehabilitation. Community nursing staff showed us their personalised care records on the electronic record. We saw several care plans that had been adapted to be person centred.

We observed staff discussing plans of care and saw that the views of patient's families were taken into consideration. Staff had been involved in active conversation with families

Community services for adults with long-term conditions

regarding patient care. Staff in the virtual ward team told us that end of life care planning involved patients and relatives, and may include discussions about preferred place of death.

Goals and timescales were revised with patients where needed such as when the frequency of specific therapy or exercise had to be reduced due to the patient's condition. Care and treatment records showed that consent was agreed with the person and checked at each session.

Patients with long term conditions had annual review of their plan of support as necessary which was completed with the patient. Such regular review is coherent with NICE guidelines for people with conditions such as multiple sclerosis or Parkinson's disease. This meant that people were involved fully in the planning of their care and treatment.

Emotional support

We spoke with patients who were receiving support at home for their neurological rehabilitation who told us they had received very good support. Staff also told us how issues were managed sensitively so that carers were supported effectively; they said this was important as long term rehabilitation can also be stressful for families and carers. We spoke with patients who told us they recognised the way in which the different therapists worked together and with the patient to deal with their varied needs. We observed a patient receiving chemotherapy at home. We saw the nurse had sufficient time to allow the patient to discuss fears and anxieties around their treatment.

We spoke with clinical psychology staff in different locations who said they worked closely with other staff in the multidisciplinary teams and provided support to help people come to terms with new disability and becoming positive about long term rehabilitation. We saw that counselling was provided within the remit of the psychology staff or people were referred as appropriate.

Are community services for adults with long-term conditions responsive to people's needs?

(for example, to feedback?)

Services were responsive to patients with long term conditions. The trust and staff in clinical teams were aware of people's complex health needs and services were well coordinated to meet those needs. Access to services had been improved through single points of contact. Access to care was enabled for vulnerable people such as the homeless by arranging drop in clinics in the community.

Meeting people's needs

The trust provided nursing and therapy services to support people with their long term conditions and rehabilitation in inpatient units, in people's homes and at specialist clinics and group sessions in the community. This meant that patients received an integrated service through hospital admission back to their home. Therapy staff told us they provided cover through the week including weekends for rehabilitation in some inpatient wards to ensure patients continued their rehabilitation each day of their hospital stay. Staff told us they undertook home visits to provide assessment and therapy if patients could not attend clinics or did not wish to join group sessions. Staff told us that the trust had invested in appointing community matrons following recognition of increasing numbers of frail elderly patients with complex needs.

We found the trust had improved coordination of care packages for patients needing integrated teams to provide support at home. We saw that rapid response team and rehabilitation and reablement teams had been established in the different areas of the trust with the aim of preventing hospital admission. Staff told us that as an integrated health and social care team it facilitated the setting up of long term care packages and reduced delay in transfers of care.

We spoke with patients who were receiving support at home for their neurological rehabilitation. One patient told us that staff had listened to their concerns and symptoms and helped them to effectively manage their pain control. Another patient who had complex range of needs had received support to manage a problem of falling. After therapy support the patient told us they had been able to meet their agreed goal and reduce the regularity of their falls by half. We found that patient's specific needs were considered in how goals were developed. We saw that therapy staff had readjusted goals in order to accommodate the patient and family's cultural views. We saw that patient satisfaction with community teams was recorded and was consistently high in the records we saw for the six months prior to our visit.

Community services for adults with long-term conditions

At an exercise group for rehabilitation of stroke patients we observed that popular music was being played. The session was well ran and engaging for most people and the staff were caring and empathetic however the music was not appropriate for the elderly participants who at times found it difficult to hear instructions and follow the exercise session.

We saw excellent examples of the trust promoting and managing the service in a way that encouraged attendance and take up of treatment and care. We found that homeless people were able to attend a drop in clinic which was led by GPs, nurse practitioners and a multidisciplinary team to manage a range of conditions. The drop in clinic allowed homeless people to access medical care for their known diagnoses such as diabetes and receive screening for other conditions. For example we found that patients attending the clinic were able to receive testing for liver conditions.

Access to services

Community services were provided in people's home as needed and clinics and groups were established in community locations. Therapy staff undertook home visits where needed. The trust had collaborated with other authorities to develop referral arrangements enable people to attend leisure centres to continue exercise for rehabilitation. We saw that the trust supported a programme of enabling people particularly with rheumatoid arthritis to attend a series of ten sampler sessions of different exercise in community locations in order to find suitable exercise for their personal preferences. This was also encouraging people to have social interaction despite the difficulties of their condition.

Staff in the Southampton RRT had robust systems in place to triage and prioritise the referrals. They said they were able to respond within two hours if there was an urgent need. There was good communication and use made of other organisations to support people at end of life. The rapid response team worked with Marie Curie nursing service and local hospice services to coordinate care at home including out of hours support.

Cardiology clinics were providing a wide ranging service to patients allowing them to see a GP with special interest in heart conditions, see specialist practitioners, undergo tests and receive advice about their condition in one place. This was convenient for patients and allowed good multidisciplinary working including with GPs.

We found that some patients had experience of services being restricted to people with specific needs. At an open meeting of patient users we were told that access to podiatry for diabetes patients had become more difficult. We were told that diabetes patients have to have 'relatively severe' foot problems before meeting the criteria to be seen for podiatry support. We were also told that people with continence problems could only be supported by the continence service if they also had a diagnosis of dementia.

The trust provided a translation service; its staff would visit services to provide interpretation and cultural support to patients. One member of staff told us they had used the translation service successfully and they were often able to use a family member to interpret. We saw community nursing staff were able to make adjustments to their schedule and make an afternoon visit so their patient could attend a podiatry appointment.

Care co-ordination

We saw that rehabilitation teams were established with a remit to encourage early discharge or prevent admission if possible. This meant that patients could receive a service where appropriate for their condition without the risks of a hospital admission or benefit from early discharge. Patients referred for multidisciplinary support for rehabilitation were seen within five days if classified as urgent and within two to three weeks if non urgent. Staff told us that community matrons had managed cases to rectify problems so patients were effectively supported despite a hurriedly arranged or poorly planned discharge from hospital.

Southampton rapid response team told us they were able to meet their targets to assess people for urgent support if they were accepted to the service. The district nursing service were meeting people's needs when referred for care and treatment although in some of the localities this was achieved by staff regularly undertaking extra hours. Staff told us this was because teams were not resourced according to the locality needs

Staff told us that specialist equipment, such as equipment required to care for patients who were very overweight, could sometimes take longer than expected and delay patients discharge from hospital.

Community services for adults with long-term conditions

Learning from experiences, concerns and complaints

We found that community teams had used complaints and incidents to improve the service. Staff showed us that patients were given information on how to complain. We saw there was a clear complaint process is in place and that there was effective handling of complaints. Staff in the PRRT told us that any learning from complaint investigations was shared with team. In patient held records we examined we saw a patient information leaflet about how to contact patient advice and liaison service and how to complain or pay a compliment.

Staff told us about their monitoring of incidence of pressure sores and we saw that trust wide reports of pressure sores were communicated to the specialist nurse to provide support to community teams in preventing similar incidents.

Staff described how a serious incident had been investigated thoroughly by the trust and referred for external investigation. The results had been shared across the trust and had led to improved safeguarding training for staff, clear flow charts displayed to remind staff of procedures, and staff given safeguarding handbook with contact numbers to ensure appropriate reporting. In addition staffing levels had been increased in teams where there had been a risk to patient safety

Are community services for adults with long-term conditions well-led?

Services were well led. There had been some restructuring of teams and further changes were planned due to contract changes. However staff we spoke with knew about the trust's aims and objectives. Staff told us they could raise issues if needed with their manager. There were risk management systems in place and clear systems for staff to report incidents or any concerns, and for the trust to investigate and share lessons learnt with staff.

Vision and strategy

Staff at the Southampton rapid response team told us that their part of the service had been visited by the trust chief executive recently who had spent time with the team. Following the visit recommendations were made aligning service improvement with overall trust vision and values. Staff in all areas were familiar with the overall strategy and the framework for this was displayed in many areas we visited. One community staff nurse was able to describe how the 'Solent wheel' related to the organisations values, quality of care and patient experience. Staff told us that their personal objectives in appraisals related to the overall values for the trust.

The trust had developed a strategy to support people with managing long term conditions; this was outlined in the document Clinical Strategy for Adults, Frail Elderly and Long Term Conditions. The strategy recognised demographic changes and expected needs of local people. Clinical structures in the Trust had been arranged to promote multidisciplinary working and link to other health providers in the area. We saw that key aspects were in place showing how the trust had implemented the strategy. This included access through a Single Point of Access (SPA); arrangements of teams in localities to improve efficiency and effectiveness; providing integrated care through the use of agreed pathways especially for patients with complex problems; one stop clinics; virtual wards and closer working with GPs and primary care teams.

Staff in all areas told us there was good multidisciplinary working and we observed good discharge and admission prevention arrangements which enabled people to receive effective care or rehabilitation in their homes or community bases

Governance arrangements

There were clear lines of accountability and we found that managers were monitoring performance of clinical staff affecting patients such as pressure area notifications, falls or other untoward incidents. Staff also described the working relationships across multidisciplinary teams and with other organisations that allowed good communication about transfers, discharges and continuing support for patients with long term conditions.

Although there had been changes of management arrangements, and some further changes for clinical staff were expected, therapy staff told us they thought services were well managed and effective as they were supported to undertake their role. Staff in the Southampton RRT told us that a clinical governance forum had been set up two months prior to our visit and this would review overall performance and safety of the service.

We saw that mandatory training for some topics was completed by staff using computers. Many staff felt that the computer based learning was not user friendly. Some staff

said that child safeguarding was outside their range of experience and should be taught 'formally' in the classroom to enable reflective understanding through discussion.

In some district nursing teams staff told us that there were not enough staff for the local activity levels which meant that they were working additional hours as overtime regularly and this meant that supervision meetings were difficult to achieve on a regular basis. Staff said that recruitment had started to resolve this issue.

Leadership and culture

Staff we spoke with knew who their manager was although some staff said that above their immediate line manager the managers were not always visible or showing clear leadership. We found that community virtual wards were well led by clinicians and there was an effective system of review of patient's needs in weekly multidisciplinary meetings. Some staff in localities said they felt they worked in a very integrated, effective and supportive team of community nurses.

One newly registered professional therapist told us they had chosen to work at the trust because they had been extremely well supported as a student. In addition they said that although they had been anxious when newly registered the trust managers and staff had been provided intensive preceptorship to enable them to gain confidence in the new role.

One member of nursing staff told us about witnessing an upsetting situation with a patient. They said they had received very good support from managers and their team members. A senior clinical specialist had attended a staff meeting to support the team on the issue. One team leader said that recent restructuring and staff moves had caused some lack of clarity over roles which had been worse due to previous staff vacancies, the staff member said that communication had not always been effective about the changes.

Acting on feedback

Community teams received feedback from patients through a variety of means. Teams had different ways of ensuring patients provided feedback on their service. This meant that there were some inconsistencies in the extent of feedback sought and received and therefore not all patients were able to provide their views. We found that the Southampton rapid response team had not sought patient satisfaction information for the two years prior to our visit. In the PRRT staff told us that patient feedback is shared with the team via email and in team meetings.

There were good examples of community teams working hard to regularly gather the views of their patients. The community stroke team in Southampton showed us how they track monthly feedback results and how they review these to respond quickly to any drop in satisfaction. The trust had supported the establishment of a stroke patient and public engagement forum. Overall patient satisfaction for the community stroke service was 98 per cent positive for the year to March 2014. In the cardiac rehabilitation service a patient experience questionnaire was given to every patient on completion of their course of rehabilitation. February 2014 results showed 98 per cent satisfaction

We spoke with people receiving support by the community nursing and care team. One patient told us that when they asked for a different carer the team leader had been able to follow their wishes.

Continuous improvement and innovation

Staff told us that managers were approachable. Staff said they had reported problems of poor computer access, lack of computer terminals or laptop and poor mobile working hardware. However staff said they felt they had been listened to by managers and were confident of improved supply of technical equipment for recording their activity.

We saw that the trust evaluated initiatives to assess effectiveness. We saw a detailed report about the falls coordinator and how the service had evolved to target the work most effectively. Staff in one of the rapid response teams told us about a detailed cost efficiency evaluation that was carried out for their team. The report had been openly shared with staff and with the commissioners of the service.

Patients receiving rehabilitation support told us they had noticed very positive team working in the service.

End-of-life care

Information about the service

The Trust provides a range of community based end of life care services. There were significant differences in the provision of delivery of end of life care in different geographical areas of Solent NHS Trust. End of life care may also be referred to as "palliative care" and both terms are used in this report. Palliative care aims to improve the quality of life for patients who are living with an illness that limits their life-expectancy. It also helps their carers' and those close to them. Palliative care is available at any point during a life limiting illness, not just when patients are nearing the end of their life. The palliative care approach is used for all on-going life-limiting conditions, not just cancer.

The Solent Specialist Palliative Care Team (SSPCT) is responsible for delivering specialist community services to individuals with a life-limiting illness, whilst also leading Solent NHS City and the Solent East area. This works across the PO1–PO6 catchment area, as part of the new commissioning contract with Portsmouth CCG.

The service's remit includes the core work of providing assessments and on-going specialist support to patients who are in the last year of life. They could be experiencing complex difficulties which may be related to symptom management, functional ability or psychological distress. SSPCT is therefore a multidisciplinary team encompassing consultants in palliative medicine, clinical nurse specialists, physiotherapists, occupational therapists and specialist clinical psychologists.

In-patients are cared for in Jubilee House in Cosham, Portsmouth, and the report for that appears elsewhere within the Solent report.

In Southampton, the specialist palliative care service is provided by the acute hospital trust. Solent provides a palliative care service, identified as a need through the local District Nursing service. The care is delivered in patient's homes by care support workers with specific training in palliative care and in communication strategies.

As part of the inspection, we visited both end of life teams and the inpatient unit at Jubilee House. We spoke with approximately 41 people, including patients, staff and relatives, and reviewed information from comment cards that were completed by people using the services. We observed care and treatment, and looked at care records. We also reviewed performance information about the Trust.

End-of-life care

Summary of findings

We found that the end of life care service was safe, mainly effective, caring and responsive to the needs of the populations it served. The end of life care service was outstandingly well led in Portsmouth.

Services were safe. There were arrangements in place to minimise risks to patients and to staff working alone in the communities. Staffing levels were appropriate to the needs of the service. There was a consistent approach to reporting incidents and these were generally well followed up and the results fed back to staff. There were effective systems in place to learn from any reported incidents. However, sharing of information across both teams was not common practice.

Services were generally effective, evidence based and focussed on the needs of the patients requiring end of life care, and their families. We saw and heard of some examples of excellent collaborative practice and this added value to the experience of the patient being cared for.

Services were exceptionally caring. Patients and their families told us how well cared for and well supported they felt by the end of life care services. All care was delivered with respect, specific knowledge and great compassion. Staff were clearly proud of their service and actively made plans to further improve it.

Services were responsive to the diverse needs of the populations it served. We found that they took note of individual requirements and ensured that anyone who wished to access the service was enabled to do so.

Services were exceptionally well led in Portsmouth, with effective direction, planning and clear decision making and communication. Risk management systems were in place, and staff were fully aware of their responsibilities in reporting and in implementing new practice.

Are end-of-life care services safe?

Services were safe. There were arrangements in place to minimise risks to patients and to staff working alone in the communities. Staffing levels were appropriate to the needs of the service. There was a consistent approach to reporting incidents and these were generally well followed up and the results fed back to staff. There were effective systems in place to learn from any reported incidents

Safety in the past

We found that systems to keep safe from harm or abuse had been in place, and staff had been trained to ensure they recognised signs of abuse or potential abuse. Lone worker policies had been in place and were strictly adhered to by staff working in the community. The community palliative care team in Portsmouth actively monitored and reported upon its' previous performance. These included patient satisfaction surveys which improved steadily upwards over the last three years. The Southampton team did not evidence such a robust system of active review, but this was due to a current lack of manager, and was being currently addressed. They did however collate patient and family experience data, although little analysis of this was able to be viewed.

There was an effective process for reporting and managing incidents. Staff felt confident about the reporting of incidents procedure, and said they were actively encouraged to report these. There were no current serious incidents requiring investigation, or medication errors being investigated.

The service actively worked on the Trust's commitments to reduce pressure ulcers by 35%. The trust's rate for new pressure ulcers was typically above the national average, but it was following the England trend of a general decrease in new pressure ulcers and most of these occurred in the community. The Trust required staff to report all grade 2,3 and 4 pressure ulcers and had introduced processes for reviewing all incidents to identify if avoidable or unavoidable. The Trust's rate for falls with harm was above England's average for most of the previous 12 months, but it had started to reduce .

Learning and improvement

Learning and action was evidenced to take place from any incidents, and as a result of performance monitoring.

End-of-life care

Incidents were recorded appropriately and in a timely manner. However, not all staff were aware of incidents reported within the organisation or of lessons learned following an review of these.

Peer review of case loads took place, particularly in more "challenging" cases, and this provided high expertise and also peer support around decision making.

Electronic notes were shared with community nurses to increase the level of communication available to all teams. Staff told us there was a culture of open-ness and of learning, and of effective joint working with the community matrons.

The Southampton carers told us how beneficial they found this level of peer support, and described themselves as a "Close-knit team who talk to each other frequently about our patients". There was little shared learning between the Portsmouth and Southampton teams, but this is planned for the near future.

Systems, processes and practices

There were reliable systems in place to maintain the safety of patients and staff. We read a well-structured patient assessment proforma and saw that records were input via the RIO electronic notes system. This meant that patient records were stored in accordance with Trust Policy and allowed access by those with the appropriate authority.

All staff had received mandatory and statutory training in the key areas of medication, fire safety, infection prevention and control, falls prevention and safeguarding of adults and children. Staff we spoke with were clear about their responsibilities regarding safeguarding and understood how to escalate concerns swiftly and through the appropriate channels. We noted safeguarding procedure leaflets in people's homes.

We were shown the Trust's Lone Working policy and advised this was usual daily practice. The staff we spoke with confirmed these safety procedures took place. There were clear communication processes in place enabling the Southampton team of care workers to receive up to date information and advice from their local District Nurse team.

Staff followed the Trust's guidance on "bare below the elbows" and hand hygiene. We observed staff using portable hand gels before and after patient contact during home visits. They also had access to personal protective equipment such as aprons and gloves.

The locations we inspected were fit for purpose, clean and with effective infection control mechanisms in place. All equipment in use by the community teams was in a fit state of repair and well maintained. Contracts for annual checks of equipment were in place.

Monitoring safety and responding to risk

Patient records clearly demonstrated that staff used nursing care pathways effectively. Any issue regarding patient safety was discussed with other relevant colleagues and actions were then able to be taken if patients were identified as being at risk. For example, the community dietician was able to be contacted and to contribute where a person with nausea had little appetite. In this way, mechanisms were able to be employed to ensure the person received adequate nutrition.

Root Cause Analysis was carried out by senior nursing staff where required. This enabled the teams to put appropriate action plans in place to aid improvement where any area of error had been identified. Medications management in the community was actively reviewed. Audits of syringe drivers were in place and this ensured that senior staff were constantly aware of these and their associated potential risks. We noted that whilst several nursing staff were independent prescribers, this was not always actively peer reviewed.

We were told by the Portsmouth palliative care team that they had an open culture, sufficient staff and excellent support mechanism including very good administrative support. This meant that there were sufficient staff to manage their caseloads safely, have time for peer review and teaching and, if necessary, flag up any concerns. Staff said they were actively encouraged to raise any queries about their caseload and their current practice, and they felt this was dealt with supportively by their senior manager.

Anticipation and planning

Staff routinely carried appropriate risk assessments to identify patients who may be at risk of harm. These risk assessments included pressure ulcers, venous thromboembolism, falls, nutritional support and infection control risks. The results of these were documented within patient records and notified to multi-disciplinary team members as necessary. Individualised care plans were then actioned and reviewed as necessary. The teams we

End-of-life care

inspected had regular contact with other staff such as General Practitioners, District Nurses and social workers. This meant that all staff likely to be involved in someone's care were kept fully informed.

Systems and processes were in place to identify and plan for patient safety issues in advance. Areas of key concern, such as safe staffing levels, infection control policies and emergency plans had been addressed. For example, there were plans in place to continue to deliver effective staffing in the community if staff were off sick, or unable to attend because of prolonged bad weather.

Are end-of-life care services effective? (for example, treatment is effective)

Services were generally effective, evidence based and focussed on the needs of the patients requiring end of life care, and their families. We saw and heard of some examples of excellent collaborative practice and this added value to the experience of the patient being cared for.

Evidence-based guidance

Multi-disciplinary team meetings in Portsmouth are in line with national guidance (NICE) Standards for palliative care. Evidence-based practice takes place, and is aligned to approved care pathways for end of life care. The Trust has collated their response to the withdrawal of the Liverpool Care Pathway, and this demonstrates well-evidenced guidelines for the near future. Mental Capacity Act training has been undertaken by all nursing staff, and they were clear about their safeguarding and consent responsibilities, particularly with regard to "Do not attempt Resuscitation" (DNAR) forms and Advanced Directives.

Monitoring and improvement of outcomes

Both community teams monitor and improve quality care and treatment by the use of specific measurements. The Portsmouth palliative care team use extensive amounts of data and key metrics to regularly review their practice, and to provide benchmarks against others. The Southampton team's use of quality frameworks is more rudimentary. However, it is in place, and the care provided by this team of non specialist staff is very good. Because the two teams are different in structure and format, an exact comparison between the two is neither helpful nor appropriate. However, the Southampton team could further enhance the delivery of their care by increasing the effectiveness of their current care measurement system. The Portsmouth team audit their Gold Standard Framework meetings, and both teams use patient satisfaction surveys to highlight areas in which delivery of care and support may be able to be improved. The results of these inform future practice.

Staffing, equipment and facilities

Staffing is currently appropriate for both teams. There are sufficient staff to provide a competent, flexible and knowledgeable team. This meant that patients were kept safe and received the right level of care.

Portsmouth palliative care team have a skilled administrator, and this "releases time to care" by providing a sound back up for the rest of the clinical team. This impacts positively and directly upon the high level of service able to be delivered, and is an efficient use of personnel resource.

The current lack of a senior manager in Southampton does not directly impact upon the care that is delivered effectively by non-specialist staff. However, this has recently been recruited to, and the commencement of this post will provide a degree of overarching support, responsibility and quality review currently outside the remit of the senior care worker.

Training is delivered across the Trust, to fulfil both mandatory and statutory requirements. The Southampton support workers have regular clinical supervision meetings with local District nurses who are able to oversee their clinical practice. The support workers told us they found this beneficial, and supportive. This provided them with a semi-formal gateway to raise practice issues and voice any concerns they may have. The District Nurse who is their nominal manager was described as helpful, pleasant and supportive.

Multidisciplinary working and support

The Portsmouth palliative care team work in a highly collaborative and multi-disciplinary manner. They share information efficiently, and are pro-active in meeting people's needs. Joint evaluation leads to swift decision making and appropriate changes to care where necessary. There is demonstrable evidence of research-based practice and peer review of work in the community. There is a current innovation to support further community care with access to an "Early stages" clinic. This is not yet fully utilised to capacity as local GP's are not yet referring many early stage patients. The reasons for this are currently being explored, as this has the possibility of being an extra

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pathway to provide strategy and help to those in mid stage rather than end stage illness. This could be highly effective once the take up rate has improved upon the initial referrals.

There is currently little evidence of the Southampton non specialist team working with the Portsmouth palliative care team. However, they do work collaboratively with more local nursing teams. On one of our home visits, we saw an excellent piece of collaborative working with the district nurse. She attended the carer's visit, to establish whether a piece of equipment in use was still appropriate to the changing needs of the family. In this way, a high degree of specific and targeted care was achieved in a timely manner. This provided excellent and appropriate care not just to the patient, but also to the family.

Are end-of-life care services caring?

Services were exceptionally caring. Patients and their families told us how well cared for and well supported they felt by the end of life care services. All care was delivered with respect, specific knowledge and great compassion. Staff were clearly proud of their service and actively made plans to further improve it.

Compassion, kindness, dignity and respect

We visited patients and families in their homes to observe the interactions and support needs. We did not view personal care being delivered. We spoke with patients and their families, read care notes and the quality reporting sheets. In both teams, the care delivered was consistently of the highest standard, and was outstanding. Families told us of their active and continuing involvement in care, in decision making, and in planning for the future. Despite the difficulty of their personal situations, they were keen to tell us of the work and the positive impact all members of the teams had.

Patients told us they felt safe and well-cared for. One relative in Southampton told us that the team "cherished" their family member and actively checked on his emotional status and needs on a regular basis. We heard many positive comments about the physiotherapy and occupational therapy teams. One person told us they could not imagine how they could have done without the staff.

Other comments we heard clearly demonstrated staff at all levels of the organisation, and in many different professions, were delivering care of the highest possible standard.

Informed decisions

Patients, family and friends all told us they were kept well informed, and were dealt with and cared for in a highly respectful manner. We saw staff behave in a compassionate and professionally appropriate manner, giving care where required and helping patients to be self-sufficient where they wished to be.

All people we spoke with in the community knew how to access the teams during normal "work hours" and also during "out of hours" when help may be required. Care plans that we read were highly detailed and had appropriate risk management plans to be read alongside them. Planning for the future was designed and planned in advance so that everyone could have an agreed idea of what the likely pathway of care should provide. Individual's requirements were taken into consideration when these care packages and pathways were written. For example, one person wished to sit in a particular chair rather than stay in bed. Specialist advice was sought from a district nurse highly experienced in this area. This ensured that the patient and their family had the precise care they wished, rather than a package of care delivered which did not meet all of their personal requirements.

Emotional support

Staff addressed patients in their preferred manner, gave choices and respected changes of preferences. The staff we spoke with, on both teams, had extensive training in communication skills and how to handle "difficult" conversations in a pro-active and compassionate manner. People told us how they felt emotionally supported by the staff and how they built warm and trusting relationships. They told us they felt able to have emotional and distressing conversations, knowing that they would be helped and supported in a warm, confidential and compassionate manner.

End-of-life care

Are end-of-life care conditions services responsive to people's needs?
(for example, to feedback?)

Services were responsive to the diverse needs of the populations it served. We found that they took note of individual requirements and ensured that anyone who wished to access the service was enabled to do so.

Meeting people's needs

Both teams told us of the triage system they used to ensure that people who needed to use their service were "flagged up" to them in an appropriate manner. The Southampton palliative care team, although lacking a local manager, described how they were able to take referrals on "almost immediately" if they had the capacity. They did this with the aid of the local District Nursing team to support them.

The team had no waiting list at all when we inspected. We read notes where a patient was referred to them in the morning, and had been seen and had a preliminary assessment by the end of that day. This was clear evidence of good practice. This meant that the person's requirements were swiftly recorded, and an action plan, care plan and risk assessment set up. In this way, her support visits were able to be started within 24 hours.

Care plans and patient records were person centred and met people's needs, maximised comfort and demonstrated the delivery of a very good service.

We saw that the diversity of patients was fully recognised with support mechanisms put into place. These incorporated translator services where a translator visited the home with the carer, in order to fully establish what the specific requirements were of someone whose first language was not English. Audio tapes, Braille publications and language specific information were also available. We heard there were some Easy Read leaflets in production as these had been assessed as a possible need for people who wished to use the service.

Because staff had undertaken mandatory training in the safeguarding of children and vulnerable adults, they were aware of their responsibilities and requirements of the Mental Capacity Act 2005.

Where necessary, staff had performed mental capacity assessments if patients could not make decisions for themselves. Where these had been carried out, this was clearly documented in patient notes. Where patients lacked capacity to make decisions about their on-going care, staff actively sought consent from family members or their representatives. If this was not possible, multi-disciplinary staff teams made the decisions about assessments, treatment and care in the "best interests" of the patient. Patient's representatives were involved where this was possible.

Access to services

The Portsmouth specialist palliative care team told us how important it was to "Get the right care, at the right time, in the right place". They described the Key Transitions clinic they had set up. This was a palliative care early referral clinic which aimed to offer a well-timed intervention, to empower patients and their carers to manage and "drive" their own care at a pace that suits them. The clinic was in its fourth year and had not been as well utilised as the team might have hoped. Feedback from patients who had attended had been positive.

Some members of the team thought the name of the clinic had not clearly defined its role. This was under discussion at a meeting whilst we inspected. Discussion took place and showed that referrers seemed to be unclear when to refer. The Specialist Palliative Care Team was keen to take the positive elements learned from the clinic process and re-market it to GP's. This would mean that fuller understanding may deliver a benefit to some patients currently not able to access this as they are unaware of it. This would allow the specialist team to see patients at an earlier stage in their illness and empower them to make informed healthcare choices.

Care co-ordination

We heard of excellent communication between various teams, and different professionals. There was much cooperative inter agency work with local social work teams and integration with GP teams. This provided a high degree of co-operative working.

We did note however that the Portsmouth specialist palliatvie care team and Southampton palliative care teams, whilst significantly different, also had much in common. They had not met each other until our inspection, and this opportunity provided some

appropriate cross-team information sharing from which patients may benefit. Effectiveness monitoring was not shared between the two teams and that may be a potential area of good practice to explore.

Staff accessed equipment in a timely manner and this ensured that specific care could be carried out according to the changing needs of the patient.

Learning from experiences, concerns and complaints

The patient feedback forms used by the Southampton team were collated, but little quantifiable data had been extracted from it and this led to a potential lack of learning from patients and families experiences. Because of this lack of monitoring, it was not possible to track any concerns or themes in order to see if any trend emerged. This led to a lack of robustness in quality outcomes.

The Portsmouth specialist team had a rigorous and robust reporting mechanism for collating data. This formed part of their extensive quality auditing and analysis system. Staff meeting minutes addressed any areas of concerns and detailed action plans were put in place to action appropriate change in a timely manner.

Benefits gained from this could be feedback to both teams to improve the patient's experience of community palliative care.

Are end-of-life care services well-led?

Services were exceptionally well led in Portsmouth, with effective direction, planning and clear decision making and communication. Risk management systems were in place, and staff were fully aware of their responsibilities in reporting and in implementing new practice.

Vision and strategy

The Portsmouth specialist palliative care team benefitted from exceptional local leadership. We were told by the staff that they had a new manager who had taken time out to understand who the team were, what they could contribute and how they thought they could further improve. They told us they deeply appreciated this. This new manager came from a therapy background. The staff said this meant that there was a swift appreciation of what they were, and what they could become. They told us how they felt appreciated and valued by the local leadership, including the team leaders.

All staff we spoke with were able to describe the Trust governance framework, and what that meant when applied to their practice.

We asked this team about the senior and executive management team. We were told that their divisional manager was "On board, on side, and always listens". We asked them what this meant in day to day practice. They described a clear decision making framework which was known to all staff. They said they were aware of and fully committed to the Trust strategy and vision, known locally as the 'Solent quality wheel.'

Governance arrangements

Quality management parameters were part of team meetings and staff could identify where they thought their team needed further resource, or could further improve. Clinical audit took place in the specialist palliative care team. However, it would be beneficial if this practice audit could extend to other team members who use independent prescribing within the extended service. This would provide a clear benefit of rigour to the role of independent practice.

Information relating to performance parameters and key objectives was in place, and was discussed at team meetings. This meant that staff were aware of incidents, performance and future plans they may be working towards. Any identified risks to the service were escalated to the Board through governance frameworks, committees and steering groups. Where risks had been identified to the service, information sharing took place at a multi disciplinary level to ensure a robust action plan was known and acted upon in a timely manner.

Leadership and culture

All the staff we spoke with were positive about their work and highly motivated to improve a good service.

The Portsmouth specialist palliative care team had regular team meetings, including periods of team building, reflection and planning for the future. They described an open and approachable leadership style with high visibility. They told us the trust shown by their senior management permeated the way in which they were led. This clearly described a strong staff team voice able to work for the benefit of the patients and families they cared for, whilst knowing they would in turn be supported by their senior managers.

End-of-life care

Staff further described a clear vision of who they were, what they did and how they did it. Their working practices were well organised, the office was well administered, and the multi-disciplinary team worked well together, across organisational boundaries. All staff were actively engaged in improvement and displayed a pro-active and "can-do" approach to their work. They described how the work could be stressful and emotionally wearing, but that they felt well supported. The clinical psychologist from the Rowans Hospice was indicated by the team as a very valuable resource which helped them to function to maximal capacity without emotional overload.

The Southampton palliative care team, whilst delivering excellent care in patients' homes had a less developed plan for the future. The senior managers were aware of this and we were told that time and senior staff would be given to achieve this parameter. The current manager leads "from a distance" because of her own substantial case load. She was able to describe how quality assessments and continuous improvement could look in the future. We have noted under the headline "Things the Trust should do" a suggestion that senior nurses from all Solent palliative care teams teams could meet with their counterparts for mutual support and to agree parameters for practice and review.

Acting on feedback

Clinical audit and peer review took place in a safe and transparent manner, thus helping the team to constantly evolve as the patient needs changed. Governance and reporting mechanisms were in place, and the reporting systems were said to be strong.

Staff reiterated they were proud to work for their Trust, and had a strong team identity. They told us that, whilst meeting targets was an understandable priority of senior managers, the staff were supported to attend further training to improve the service to patients. This meant that staff were further encouraged to develop their skill base. This "striving for learning" demonstrated a clear executive regard for team sustainability.

Continuous improvement and innovation

Staff had benefitted from an extensive professional training programme. This was a mix of statutory and mandatory training. Some of this was online training. Staff told us this delivered benefit as they could refresh their training from the comfort of their own home. One person commented that they preferred "classroom based" training as they thought it delivered further benefit because of the social interaction and exposure to other's views.

There was much evidence of clear and effective feedback and guidance from senior managers.

The specialist palliative care team continue to market a new clinic to achieve further benefit to their local population.

Other services: Sexual health services

Information about the service

Solent NHS Trust delivers a range of integrated sexual health services across most of Hampshire, Southampton and Portsmouth. The rates of sexually transmitted infections and teenage pregnancy are worse in Portsmouth and Southampton than the England average. Although Hampshire's rates are better than the England average, there are localised pockets of deprivation where rates are higher than the local authority average. The range of sexual health services provided by Solent NHS Trust includes:

- Sexual and Reproductive Health (SRH) and Genitourinary Medicine (GUM)
- Human immunodeficiency (HIV) specialist services, including support to in-patient care
- Termination of Pregnancy (TOP) services in partnership with a private provider
- Vasectomy services, through internal service provision and contracting arrangements with primary care providers
- Psychosexual counselling and medicine services
- Chlamydia screening programme and targeted outreach services
- Targeted sexual health promotion
- Young people's drop in clinics at Further Education colleges and some schools
- Sexual Assault Referral Centre (SARC) for victims of sexual assault and rape, delivered in partnership with Hampshire constabulary.

The services are delivered through six clinical 'hubs', providing specialist community sexual health services and 14 community 'spoke' clinics sited in towns or conurbations.

For this inspection, we visited the clinical hubs of Royal South Hants Hospital in Southampton, St Mary's Hospital in Portsmouth and Aldershot Centre for Health. We visited a satellite service within Gosport War Memorial Hospital and a young people's drop-in clinic at Farnborough College of Technology. We spoke with 16 patients and 20 clinical and non-clinical staff members. Although we distributed comment cards to the six hubs, we received no written feedback from people visiting the services.

Summary of findings

People using the service told us they felt safe and were mostly treated with respect by the staff who were non-judgemental and reassuring. Some people said the waiting arrangements for walk-in clinics made them feel vulnerable and there was a lack of privacy when speaking with reception staff. When people were turned away from clinics, because they were already full, the conversations were not always managed sensitively. The layout of premises at different clinics meant that people were not always afforded adequate privacy whilst waiting to see a clinician.

The service was not always able to meet people's needs in a timely way. Staff endeavoured to see people by informally extending clinic times but at some clinics patients had to be 'turned away' and there was a risk that they may not receive the treatment they needed. The capacity of some clinics had reduced recently to accommodate a new information management and technology (IT) system and this meant patients were sometimes asked to come on a different day. Patients' views were sought to inform service design and changes had been made as a result of patient feedback. The service had staff vacancies however, which meant that clinics were sometimes closed at short notice, or provided a reduced service.

Services were safe because there were systems for identifying, investigating and learning from patient safety incidents and an emphasis in the organisation to reduce harm or prevent harm from occurring. Action had been taken to improve patient safety following incidents, which reduced the risks to patients and staff. However, improvements to patient and public safety in relation to cancelled clinics and waiting times were required.

The service took account of guidance and best practice issued by national bodies and audited its practices and performances. Staff received regular training and supervision, and were supported to gain additional qualifications and undertake research. There was effective multidisciplinary working across the service. Working with a range of partners and other services meant patients received their care in a joined up way.

Other services: Sexual health services

The trust's strategy and vision was embedded and staff reported good leadership and co-operative team working. Organisational objectives, risks and performance were monitored through clear governance arrangements.

Are sexual health services safe?

Safety in the past

We found that the Sexual Health Services division had measures in place to protect people using the service from abuse and avoidable harm. The division had appointed two clinical safeguarding leads and staff attended annual training appropriate to their roles. Staff we spoke with were familiar with the safeguarding policies for children and vulnerable adults. They knew how to contact the safeguarding teams and said they would talk to a line manager if they had a concern. There was a higher proportion of staff in this division who had completed mandatory training in safeguarding adults and children than the trust average. We saw that pocket-sized Safeguarding Adults reference packs had been issued to staff. Staff could also access trust safeguarding surgeries for advice or support, as well as during supervision meetings.

Staff were familiar with the incident reporting procedures, and said they were encouraged to complete the on-line incident reports. There had been information governance breaches reported most months for the past year, and the reporting rate had increased year on year. Incidents had been individually reviewed at clinical governance meetings. There had been no serious untoward incidents in the past year, and any high risk incidents were investigated. Trends were also captured and monitored via the divisional risk register.

Staff were kept safe. For example, outreach workers risk assessed their work in the community and felt the lone working procedures supported their personal safety.

Medicines were managed safely for the protection of patients and staff. The division employed its own HIV pharmacists to support staff and trained nurse prescribers. Nurse prescribers received training and clinical supervision and were allowed to prescribe from a list of agreed medicines. Storage of medicines, including emergency medicines, was monitored.

Learning and improvement

There was evidence of learning from incidents. Incidents relating to the delivery of medicines to people at their homes had been reported and investigated and improved arrangements had been implemented. New procedures to monitor and notify patients of test results had been introduced as a result of reported incidents.

Other services: Sexual health services

Problems with information technology (IT) were also reported as incidents, but some staff reported 'reporting fatigue' with this issue. Governance and risk reports showed this had been raised during 2013. New IT systems were planned for implementation in 2014 to improve speed and reliability.

The service produced fortnightly staff newsletters. These included summarised learning from incidents and complaints and changes in practice. The service also included learning from complaints and incidents in staff training twice-yearly away days.

Staff provided evidence of learning from complaints. For example, in Aldershot, the location of the clinic within the health centre was moved in response to complaints, to provide a dedicated waiting area with improved patient privacy.

The service's monthly Quality and Risk Report for February 2014 showed there had been between one and nine formal complaints each month during the past year. When we visited Royal South Hants Hospital we observed walk-in clinics and spoke with patients and staff. Staff told us that patients complained verbally about long waiting times, lack of clarity about clinic availability and the risk of being turned away. Patients we spoke with told us of their lack of satisfaction with this aspect of the service. The frequency of these views had not been captured effectively in the risk report.

Systems, processes and practices

Policies and safe operating procedures were designed to ensure that safe practices were in place. The service had unified policies and operating procedures across the different clinical 'hubs' and 'spokes'. The exception to this related to operating procedures with different pharmacies.

There were standardised systems in place to report incidents, refer safeguarding concerns and for medicines management. Staff said they understood these procedures, and used them. There were clear resuscitation protocols, specific for each location.

Systems had been improved to reduce the risk of information governance breaches. People who had undertaken tests were given a personal reference number to protect their anonymity. The new web-based patient records generated patient labels which minimised the risk of incorrect labelling of samples.

Monitoring safety and responding to risk

Staff said they were encouraged to report incidents and received feedback on action taken. They felt the service had an open culture and they were supported in their work. Staff cited the IT system as their key challenge. February 2014's monthly quality and risk report for the service showed that 50% of staff thought the service was less safe than six months ago. It also showed a decrease in the percentage of staff that thought the service was safe, from 85% in December 2013 to 75% in February 2014.

The complaints relating to sexual health service since July 2013 mainly related to poor communication, attitude of staff, cancelled appointments and clinics and waiting times. During our inspection, we found that clinics and appointments were sometimes cancelled or provided a reduced service due to staff shortages. We also found waiting times for walk-in clinics could be up to four hours. In Royal South Hants and St Mary's Portsmouth, we observed that walk-in clinics filled up quickly and then closed early so people were turned away.

The service monitored risks through its governance arrangements. The service had responded to the risk of people being turned away, by instigating a triage system, by asking if they had symptoms first and agreeing to see the symptomatic patients. If patients were turned away they were allocated 'priority' at their next visit. However we found these approaches were not always implemented or were considered inadequate measures when the demand was high, for example at Royal South Hants' morning walk-in clinics. One patient told us at a previous visit they had replied 'no' when asked if they had symptoms, and had left, because the triage had not been undertaken discretely. Another patient said they felt unsafe waiting in the corridor for the clinic to open. This meant there was a risk to public health that people with symptoms might not be treated. There was also a risk to people's personal safety.

Anticipation and planning

The service anticipates and plans for potential problems to lessen their impact on patients. For example, to reduce the risk of cancelling or reducing clinics, the service had accelerated the dual training programme for nurses so they could provide both contraception services and sexual healthcare. The service was on track to complete this programme by March 2014. This meant nursing staff could provide a more flexible service.

Other services: Sexual health services

There were some staff shortages when we visited and this caused some services to be cancelled or reduced. We were told that more clinics were cancelled in the west of the service than the east, and it was estimated that one clinic was cancelled each week. Cancelling of clinics was risk assessed and different clinics were cancelled to minimise the impact for patients. We were told that additional nurses had recently been recruited and the service was continuing to advertise.

The service had regular reviews of clinic timetabling, and we were told that demand for services was increasing. Havant clinic had recently extended its opening times in response to increased demand, and discussions were taking place with commissioners to review service planning. People visiting the clinics were being asked for their views on future service provision to help inform planning. The service's new IT system enabled improved data collection, to inform future commissioning decisions.

Are sexual health services effective?
(for example, treatment is effective)

Evidence-based guidance

We spoke with 16 patients who all commented that the quality of care and treatment they received was good or excellent. They said they understood the treatment, options and risks. They reported that the clinicians were skilled, reassuring and non-judgmental which they appreciated.

The service takes account of guidance issued by the Faculty of Sexual and Reproductive Healthcare (FSRH), the British Association for Sexual Health and HIV (BASHH), Children's HIV association (CHIVA), the Medical Foundation for HIV and Sexual Health (MEDFASH), an independent charity supporting policy development in HIV and sexual healthcare. For example, the service had implemented the testing of children of HIV positive parents, in line with BHIVA guidance. We saw that the updated standard operating procedures made reference to faculty guidance and best practices. Feedback from BASHH and faculties was shared during staff education sessions.

The service had a strong skill base to identify and implement updates in good practice. It had appointed consultant and nurse specialty leads, for example for HIV, contraception, genitourinary medicine (GUM) and education. In addition, there were HIV pharmacists, psychosexual counsellors, health advisors and clinical nurse specialists within the service. This meant patients using the service had access to a range of specialist support.

Monitoring and improvement of outcomes

The service had undertaken national and local audits on clinical outcomes. For example, the clinical lead for HIV outlined their participation in the national BIVA audit programme, and how this had impacted on care for patients. A case-note audit of partner notification for patients with HIV had resulted in more rigorous systems for contacting partners. Staff also summarised audits of incidents of sexually transmitted diseases which had, for example, led to improved recording of patient information. In addition, the service had taken part in the national chlamydia screening programme and a survey of provision of psychological care and adherence support.

From governance reports and talking with staff we found that healthcare professionals actively shared learning from research and attendance at conferences. For example, monthly education sessions were used for presenting research papers.

Local audits of performance were undertaken, for example to assess waiting times for clinics and to audit the amount of time doctors spent with patients referred from nursing staff. These were reported in clinical governance meetings to improve services.

Staffing, equipment and facilities

There were differing staff views across the service about their ability to meet the needs of the volume of patients using sexual health services. Although the service had increased the number of dual trained nurses, trained clinical nurse specialists and prescribers, clinics were still sometimes cancelled or reduced due to staff shortages. Clinics were run by small teams of staff. If the skill mix of qualified and competent staff was disrupted due to staff absences, this meant clinics were cancelled or offered a reduced service.

There was a known underspend on staffing in administration, nursing and speciality medical staff. We were told staff recruitment was challenging but additional nurses had recently been recruited and the service was continuing to advertise.

Clinical staff reported excellent access to training and support. There were examples of staff being supported to

access relevant professional development and there was protected time for regular internal education sessions. For example, the service had protected time each month for in-house training. The trust had established learning groups for staff, such as the nurse prescriber forum. Nurses and healthcare support workers had regular monthly meetings and supervisions. A 'buddying' system and a mentorship programme were in place to provide tailored support for healthcare advisors and clinical staff.

Staff reported effective clinical supervision arrangements. There were monthly group clinical supervisions, but staff said they could also arrange these individually with their managers. Safeguarding supervisions were provided, and staff could access the trust's drop-in safeguarding surgeries for advice or support. The service's appraisal rate was 86.5%, and all staff we spoke with said the new appraisal approach was well structured and effectively linked to training and development.

Results from the national 2013 staff survey showed that staff were feeling supported by line managers. However, staff in this service also scored lower than the trust average on feeling there were enough staff, and experiencing patient abuse and aggression. Reception staff reported feeling pressured by the high demand for services that could not always be met, and having to manage challenging responses from frustrated patients.

The IT infrastructure had been a major risk within this service over the past year and was still a 'red' risk on the corporate risk register. Actions had been taken to unify IT systems across the region and implement electronic patient records. Staff commented that overall, the IT system was slow and fewer patients could be seen at clinics due to the time taken to log information. Some staff considered that they required training on how best to use the electronic patient records, to improve efficiency. The IT system was therefore reducing the effectiveness of care delivery.

Multidisciplinary working and support

There was good multidisciplinary team (MDT) working in this service. Staff worked in partnership with primary and secondary NHS services, for example for the care of HIV patients, their families and partners. Clinicians attended monthly regional HIV MDT meetings, involving health advisors, pharmacists, and consultants from the acute trust. This enabled support for people and their families with complex social or clinical needs to be coordinated effectively.

The service's safeguarding team met with teams in the local authorities, the police and counselling groups to share information about people who had experienced abuse or who were at risk.

There were links with school and college nurses and community groups as part of the service's outreach work with young people and other minority groups. We had positive feedback about collaborative working arrangements from community centres in Southampton.

The service had strong links with community groups. These included counselling and outreach groups for people with HIV, groups for black and ethnic minorities, drug and alcohol support groups and other isolated communities.

Staff reported a culture of good teamwork and cooperation. This had enabled the service to develop a more equitable sexual health provision across the region.

Are sexual health services caring?

Compassion, kindness, dignity and respect

We spoke with 16 patients at clinics or by telephone. They were positive about the attitude, compassion and non-judgemental approach from clinical staff. Patients often told us they had recommended the service to others, and had been advised of the service through friends.

At one clinic, we were told by more than one patient that they had not been fully aware of the waiting time for the walk-in clinic. They commented that this was not mentioned on the website. We received comments from patients who had been turned away from clinics for capacity reasons, saying this had not been handled sensitively.

The different types of accommodation provided at the clinics meant the level of privacy and comfort varied in the waiting areas. For example, there were separate female, male and mixed waiting rooms at Royal South Hants, but not at other clinic 'hubs' in Portsmouth and Aldershot.

Other services: Sexual health services

Patients reported that there was a lack of provision for people waiting with babies and young children. This meant that people were not assured a comfortable experience waiting for care and treatment.

We observed there was a risk that people were not given sufficient privacy at reception. Reception layouts were different in the clinics we visited, and in two of the four clinics, the waiting area was close to the reception desk, which meant there was a risk that people were overheard. This was a particular problem when people were queuing for a walk-in clinic. We also overheard this triage process taking place when we were sat in reception. This meant people were at risk of experiencing a lack of dignity and privacy.

There were arrangements in place to support the diverse needs of patients from different ethnic communities and those with specific needs. For example, there were a range of leaflets in different languages, and additional material could be provided by the trust's equality and diversity team. Staff said they had access to translation services when required. Staff used these services rather than having relatives or friends attending consultations, to protect people's confidentiality and safety.

People with learning difficulties were invited to bring their carers. The service had pictorial literature available to facilitate discussions. The service had identified that arrangements were not in place for people with hearing difficulties and this had been raised for further action.

Informed decisions

The 16 patients we spoke with said they felt fully involved in their care and understood the care or treatment they were receiving. They had time to ask questions, and risks associated with any options were discussed. People attending for contraceptive services said they were given clear advice, and a number to call if they had any problems.

We observed that patients at walk-in clinics completed registration forms which provided pre-assessment information about their care. Patients told us they found completing the registration forms helped them prepare for the clinical discussions. We were shown the new electronic patient records system, which prompted clinical staff to discuss and record patients' medical history and symptoms, lifestyle and preferred contact details. This meant staff were able to offer appropriate advice and treatment.

HIV patients receiving long term care reported full involvement in their care and confidence in sharing personal information with clinicians. They were involved in discussions about medication changes and understood the risks and benefits of different options. They reported seeing named members of staff when they visited the clinic, and having phone numbers to use if they needed to speak to staff urgently, which they appreciated.

We observed that clinics displayed a wide range of literature for patients and visitors, including age-appropriate leaflets.

Emotional support

Patients were consistently positive about the emotional support they had received. They told us clinicians were sensitive to their needs and preferences.

We observed people being spoken to with respect by staff when attending the clinics. There were a minority of occasions when staff came across as brusque when directing patients to waiting areas, and this was commented on by one patient. We spoke with reception staff. They told us they had completed customer service and conflict resolution training which helped them support agitated or anxious patients.

Health advisors provided emotional support for patients with new positive diagnoses, and sign posted them to appropriate support groups. The service employed psychosexual counsellors who provided talking therapy to patients referred by GPs.

Are sexual health services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

The service had identified issues with waiting times and people being turned away from walk-in clinics for capacity reasons. This issue, on the divisional risk register, had been raised by staff and patients. It had been exacerbated by the introduction of web-based patient records which lengthened patient consultation times. Patients and staff also told us there could be long wait times for booked appointments, and we saw complaints relating to clinics being cancelled at short notice. This meant that people presenting at the service were at risk of not having their needs met.

Other services: Sexual health services

Some patients told us that the scheduled clinic times were a barrier for them attending. For example, they commented it was hard to attend if they had work or caring commitments, as the clinics were not often available after work or were full by the time they arrived. We saw that the service undertook regular reviews of clinic timetables in response to patient feedback and needs.

Staff explained that adjustments had been set up to alleviate the issues with long wait times and people being turned away. People waiting in the queue were 'triaged' if it was likely that the clinic would be 'capped', or closed early to new patients. People were asked if they had symptoms or were vulnerable, and were seen that day if appropriate. Also, people being turned away were offered priority at subsequent clinics, however this approach was not always applied in practice. We were told that at the Royal South Hants walk-in clinics, the demand could be so high that this was not always feasible. For example during our visit, we were told there had been 40 to 50 people waiting for the clinic to open. The clinic had capacity for about 30. This meant that the clinic, advertised as in operation between 08.30 and 11.30 was effectively 'capped' at about 09.00. At another clinic, we observed a group of people arriving at an evening walk-in integrated clinic, being told they would have to return another time. They were not given a priority card to use at their next visit.

Cancelled clinics put additional demands on other clinics. A clinic at the 'spoke', or satellite site in Bitterne, Southampton, was cancelled regularly and staff reported this put the 'hub' clinic at RSH under greater pressure. We found that staff often worked beyond the advertised clinic times to meet the needs of as many presenting patients as they could.

Data was collected to inform a review of service delivery with commissioners. The service had already made minor adjustments to clinic times to meet people's needs, for example by lengthening the clinic time at Havant. It was not clear however how the numbers of patients turned away was collected effectively.

Access to services

The trust model for sexual health services provision is based on national policy and guidance issued by the Department of Health and Public Health England. Solent NHS Trust provides an integrated sexual health service, with open access 'one stop shops' at 'hubs' and 'spokes' where the majority of sexual health and contraceptive needs could be met at one site. Not all contraceptive needs however could be provided at the spoke sites, for example, they were not all able to provide intrauterine device insertion (IUD), follow up and removal.

The clinics we visited were well sign posted from the main entrance of the health centre or hospital, and were accessible for people with a physical disability or who required the use of a wheelchair.

Arrangements were in place to support people from different ethnicities and cultures accessing the services. All staff we spoke with said they could provide interpreters or use 'language line' for different translation services where necessary. Outreach teams had links with different community groups in their locality. Staff had been trained specifically to provide services for the lesbian, gay, bisexual, and transgender communities and those from black and minority ethnic groups.

Patients said the service's website was useful and informative. It gave a clear outline of the services provided and lists of clinic times. Clinic hubs could update the website directly when clinics were changed or cancelled, to ensure information was kept up to date.

The trust had set up a 'single point of access' (SPA) telephone reception service for people telephoning sexual health services for advice or appointments. This was providing a signposting service of variable quality. Patients we spoke with had a mixed view about the advice received when telephoning the service. For example, one person said they had not been warned about a potential wait, but another had been told it was best to arrive early. When we observed the SPA handling a call, we heard them providing incorrect advice to a caller, which could have put them at risk. We saw the trust had received complaints about SPA from users of sexual health services. We were also told of an incident relating to the delay in providing HIV preventative treatment caused by misdirection by this service.

Care co-ordination

People's clinical care was coordinated effectively. The sexual health service had clinical specialists that met regularly as multi-disciplinary teams, and had links with other care and treatment providers, including psychological support groups. The hub and spoke model of care for sexual health service was based on the integrated

Other services: Sexual health services

model of care advocated by the government's 'Framework for Sexual Health Improvement in England'. This meant that people's care and treatment was coordinated to meet their specific needs, close to home.

The health promotion team had developed links with primary care and services such as the drug and alcohol team and a range of voluntary agencies and community groups. Referral pathways were in place to support effective coordination. For example, children and young persons in receipt of HIV services were transitioned effectively into adult services.

The service responded to the needs of children and young people. The sexual health promotion team coordinated educational programmes with schools and outreach nursing, in line with the public health agenda. There were agreed pathways for young people attending unplanned pregnancy clinics, to be referred for further sexual health advice or treatment.

The consultant and nurse leads for HIV coordinated patient care and sign-posted patients to local support groups in the voluntary sector.

Learning from experiences, concerns and complaints

The service monitored formal complaints and actively sought feedback from patients. We saw that complaints were discussed at governance meetings and action was taken. The trust has recognised a need for improving levels of feedback across all services were on the divisional risk register. An inadequate IT system was considered a key cause. This was on the corporate risk register and scheduled for an upgrade. Actions had been taken to alleviate the problems in the short term, such as increasing clinic times, giving people priority cards and providing training in the new electronic patient records system.

Patients were asked to provide feedback on clinic opening times and their views were collated for discussion with commissioners. We found that informal complaints were not fully captured, although staff fed back people's views at staff meetings.

Are sexual health services well-led?

Vision and strategy

All staff we spoke with understood the trust's vision and values. The service's business strategy for 2012-2017 was aligned to the trust's corporate strategy based on four key objectives. Staff said their personal objectives, performance and development were linked to the service and corporate objectives.

We saw evidence of promotion of the corporate objectives and the 'Solent Quality Wheel' at the locations we visited during the inspection. The Solent Quality Wheel provided a pictorial representation of the trust's values in relation to quality of care.

Managers in the service felt there was effective leadership and teamwork, with a strong focus on quality and patient-centred care.

Governance arrangements

The service had restructured within the past year in line with trust guidance, to develop divisional service line management. The service was led by the clinical director and operations director. There were monthly clinical governance meetings and assurance meetings, which fed into the trust's assurance committee. Risks were identified, rated and escalated in line with the trust's governance guidance. For example, the risks related to IT were captured on the corporate risk register and monitored. Staff understood the key risks and the governance arrangements of the service. The service met regularly with commissioners to reflect on performance and plan service developments.

Policies and procedures had been unified in the past year, and were available to staff in electronic or hard copy format. Performance data was collated, analysed and shared with staff. Governance arrangements were in place to monitor the safety and performance of contracted services, such as the service for unplanned pregnancies.

The service's business strategy was based on the joint strategic needs assessments (JSNAs) for Portsmouth, Southampton and Hampshire. The service strategy and 2013 mid-year strategy review summarised actions taken by October 2013 to develop services in response to population needs. This review summarised progress to date, but did not highlight areas of risk or where there had been barriers to progress.

Leadership and culture

Staff reported good leadership visibility. The two non-medical clinical leads divided their time between their leadership role and clinical work and staff reported feeling well supported. There was a strong emphasis on training

and development, which staff appreciated, and clinical leaders were supported to complete leadership training. The service had initiated staff 'away days' twice a year, to incorporate education and topical subjects for discussion. Monthly clinical training days encouraged staff interaction, and reduced the risks of staff feeling isolated, as well as providing a forum for staff to update skills.

The service produced fortnightly electronic staff newsletters which helped staff keep up to date with news, guidance, performance and events.

The most recent staff survey showed that staff in sexual health services were feeling more supported by line managers. Our observations indicated the service had further work to develop a completely unified culture across the 'West' and 'East' teams, however.

Acting on feedback

The service acted on feedback. It had a range of ways of obtaining patient feedback. It had set up 'token boxes' in clinics, similar to those found in supermarkets, to obtain patient views of options, such as clinic opening times. These were used to gauge preferences between, for example, different clinic times, all day clinics or Saturday clinics. The results were used to discuss service planning with commissioners. Minutes of monthly operations meetings showed that these had been used to support the closure of some Saturday clinics.

All clinics had comment cards and boxes. Compliments, complaints and comments were reviewed and discussed at monthly clinical governance meetings and action was taken to share compliments and investigate complaints. For example, clinic closure rates were being monitored as a result of the feedback, as well as the numbers of people being turned away.

We saw evidence that patient feedback forms were issued by different clinics and services. Patients were being asked to complete feedback forms relating to, for example, staff attitude which had been raised in complaints in the past year.

Continuous improvement and innovation

The service had implemented a variety of initiatives and programmes to drive improvement and deliver cost savings. For example, there was a programme of dual training for nurses, improved systems for notifying patients of diagnostic results and protected time each month for staff training. The service successfully launched point of care testing in the community, to test for target groups for HIV during our inspection. In 2013, the service had set up a partnership contract with another provider to deliver unplanned pregnancy services, with oversight, support and training to ensure effective governance arrangements were in place.

The service was commissioned by eight Clinical Commissioning Groups and Public Health England. There was no lead commissioner and the service had regular meetings with all commissioners to review service delivery arrangements. Sexual Health Services had been set two improvement targets from the Commissioning for Quality and Innovation (CQUIN) framework, and progress was being monitored. The service was collecting data to inform service design discussions with commissioners.

The service had not always managed to minimise risks to service delivery from initiatives. The risks associated with the new web-based patient electronic records had not been fully anticipated and mitigated. Although the new system would ultimately facilitate improved data quality and data management, the IT system was not adequate to support the package efficiently. In addition, the service was not able to capture the total number of people being turned away, or choosing not to wait in line for a clinic. This meant the impact of patients not been seen in a timely way could not be assessed and evaluated.

Other services: Community dental services

Information about the service

Solent NHS Trust provides a dental service for all age groups who require a specialised approach to their dental care and are unable to receive this in a General Dental Practice.

The service provides oral health care and dental treatment for children and adults that have an impairment, disability and/or complex medical condition. People who come in to this category are those with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability, including those who are housebound.

Additional services provided are a sedation service in selected clinics where treatment under a local anaesthetic alone is not feasible and conscious sedation is required.

General anaesthetic (GA) services are provided for children in pain where extractions under a local anaesthetic would not be feasible or appropriate such as in the very young, the extremely nervous, children with special needs or those requiring several extractions. This service can also be provided for adults with special needs. GA procedures are delivered at:

- Southampton General Hospital
- Royal Hampshire County Hospital, Winchester
- North Hampshire Hospital, Basingstoke
- Poswillo Unit, Queen Alexandra Hospital, Portsmouth.

There are 18 dental clinics in Portsmouth, Southampton and the wider Hampshire area. In addition, dental care is provided at one prison in Hampshire, two prisons on the Isle of Wight, one immigration detention centre and two secure mental health in-patient units. The service as a whole processes approximately 3700 new referrals annually (based on referrals to service April 2013 to February 2014).

Summary of findings

Solent NHS Trust has 18 dental clinics across Southampton, Portsmouth and wider Hampshire area. During our inspection we visited five locations which provided a special care dental service:

Poswillo Dental Centre – special care / occasional care dental treatment under general anaesthetic.

Eastney Dental Clinic – special care dental treatment for all age groups.

Eastleigh Dental Clinic – special care dental treatment for all age groups.

Millbrook Dental Clinic – special care dental treatment for all age groups, situated in Pickles Coppice Sure Start Centre.

Andover Dental Clinic - special care dental treatment for all age groups.

We chose to inspect parts of the dental service across the area as part of the first pilot phase of the new inspection process we are introducing for community health services.

Overall we found dental services provided safe and effective care. Patients' were protected from abuse and avoidable harm. Systems for identifying, investigating and learning from patient safety incidents were in place.

Dental services were effective and focussed on the needs of patients and their oral health care. We observed good examples of effective collaborative working practices and sufficient staff available to meet the needs of the patients who visited the clinics for care and treatment.

All the patients we spoke with, their relatives or carers, said they had positive experiences of their care. We saw good examples of care being provided with compassion and of effective interactions between staff and patients. We found staff to be hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed how dedicated they were in what they did.

At each of the clinics we visited the staff responded to patient's needs. We found the organisation actively

Other services: Community dental services

sought the views of patients, their families and carers. People from all communities, who fit the criteria, could access the service. Effective multidisciplinary team working ensured patients were provided with care that met their needs, at the right time and without delay.

The service was well-led. Organisational, governance and risk management structures were in place. The senior management team were visible and the culture was seen as open and transparent. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns.

Are community dental services safe?

Safety in the past

We found the dental services protected patients from abuse and avoidable harm as staff were confident about reporting serious incidents and providing information to the team manager or senior manager if they suspected poor practice which could harm a patient. Staff told us incidents, accidents or near misses were reported on the organisations risk management system and the quality and safety department collated and reported on any trends. We found mechanisms were in place to monitor and report safety incidents, including "never events".

All staff we spoke with were aware of the safeguarding policy and had received training at the appropriate level with regards to safeguarding vulnerable adults and children. The mandatory training records reported 100% attendance at Safeguarding Adult and Children training.

At all the sites we visited clinical records were kept securely and could be located promptly when needed, confidential information was properly protected. The patient records were a mixture of computerised and hand written records. The computerised records were secured by password access. Information such as written medical histories, referral letters and dental radiographs were scanned and uploaded onto the patient clinical records. Hard copies of written information were archived in a locked and secured premise in accordance with data protection regulations.

We found medicines were stored safely for the protection of patients. A comprehensive recording system was available for the prescribing and recording of medicines. The systems we viewed were well completed, provided an account of medicines prescribed, and demonstrated that patients were given their medicines as prescribed. Daily recording of the monitoring of medicine temperatures showed staff took appropriate action to check temperatures were appropriate and the efficacy of medicines was not affected. We found medicines for emergency use were available, in date and stored correctly.

Learning and improvement

All staff were familiar with the incident reporting system and could provide examples of reporting incidents and the lessons learnt.

Other services: Community dental services

Staff were aware of safeguarding procedures and what may constitute a safeguarding concern. Safeguarding featured as a topic for discussion in staff meetings and minutes indicated that the service had safeguarding champions in each area as well as a safeguarding lead for the service. Staff spoken with demonstrated understanding and knowledge of the action they should take in the event they had suspicion or evidence of abuse.

All dental nurses had been trained to a high standard. The eight dental nurses at the Poswillo Centre have taken and passed the National Examining Board for Dental Nurses Certificate in General Anaesthesia and Intravenous sedation. The dental service has a further four nurses working at Southampton Hospital who had the same qualification. The nurses at the Poswillo Centre had undergone further training in recovery and monitoring of patients, equivalent to that of an Operating Department Practitioner. There was an exchange of personnel between each of the GA sites. This enabled good practice and ideas to be shared. These dental nurses were able to provide optimum care to patients during the recovery phase following dental surgery.

Since April 2013 the service initiated a patient satisfaction survey which was conducted on a quarterly basis. The results of the surveys were disseminated to all staff in the various clinics. The aim of the audit was that the service could act promptly to areas of concern. It would further enable the staff to understand the perception of the service within their cohort of patients. We were able to view the results of the last two surveys which showed a high level of satisfaction with the service. A summary of the results was posted on the walls of the clinics we visited to give feedback to patients using the service.

The Dental Clinical Governance Subcommittee (CGS) was set up to bring together and formalise quality, safety, patient experience, clinical effectiveness, risk and governance across the service in a coordinated and standardised way. The Subcommittee reviewed, analysed and responded to service level clinical and quality governance issues and risk. Key to this commitment was having effective mechanisms in place for ensuring the highest standards in clinical practise along with a dynamic approach to quality improvement and governance. The reports we viewed included an update on actions to date relating to issues raised from internal audits, patient surveys and complaints.

The Subcommittee reported into and provided assurance to the Assurance Committee of the Solent NHS Trust.

Systems, processes and practices

The staff reported their managers were supportive. They told us they were able to raise issues or concerns without fear of reprisal.

The provider had incident reporting policies and processes in place which were available for staff to refer to. Each of the eight team managers had an area of responsibility. We saw that the team manager reported incidents and complaints to senior managers on a monthly basis. This was then fed through to the trust board.

Throughout our inspection visits we looked at a sample of dental notes across the service. The electronic records were well-maintained and provided comprehensive information on the individual needs of patients such as; oral examinations; medical history; consent and agreement for treatment; treatment plans and estimates and treatment records. Clinical records viewed were clear, concise and accurate and provided a detailed account of the treatment patients received. Patient safety and safeguarding alerts were also thoroughly recorded. For example allergies and reactions to medication such as general anaesthetic.

We observed a very robust system for obtaining consent was carried out for patients undergoing General Anaesthesia and IV sedation. The Senior Dental Officer at Poswillo talked us through the process. The consent documentation used in each case consisted of: the referral letter from the general dental practitioner, the assessment including a complete written medical, drug and social history. Also NHS consent form as appropriate (1,2 or 4), pre-operative and post-operative check list and a patient information leaflet of pre-operative and post-operative instructions for the patient to follow. These patient instructions were reinforced verbally at the assessment appointment and again at the point of discharge following surgery. The service used the World Health Organisation (WHO) Surgical Check List process for all patients undergoing dental surgery and a 'theatre white board' which states the teeth for extraction and or teeth to be filled. The annotated teeth are crossed off as each tooth has been treated. These measures were used to prevent the occurrence of a 'never event' i.e. wrong tooth extraction.

Other services: Community dental services

The service had implemented a clinician led 'single point' system of referral for patients accessing the service. The process for Poswillo clinic consisted of a joint clinician/ administrator who carried out a triage system to assess the appropriateness of the referrals into the service and then to arrange the most appropriate clinic for the patient to visit. Very close joint working between the clinician and the administrator had evolved whereby the administrator highlighted deficiencies in the referrals to the clinician. They could then arrange for further dental radiographs, blood tests, of advice from the patient's GP or dentist, so that the patient was then seen in the right place at the right time. This system had dramatically reduced the number of inappropriate referrals to the service.

Staff were aware of current infection prevention and control guidelines and we observed good infection prevention and control practices, such as:

- Hand washing facilities and alcohol hand gel available throughout the clinic area
- Staff following hand hygiene and 'bare below the elbow' guidance
- Staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care and treatment.
- Suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.
- Cleaning schedules in place and displayed throughout the clinic areas,
- Clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Staff at the five centres we visited showed us and demonstrated the arrangements for infection control and decontamination procedures. They were able to demonstrate and explain in detail the procedures for the cleaning of dental equipment and for the transfer, processing and storage of instruments to and through designated on-site decontamination rooms. We noted that for one location the decontamination processes were undertaken in the same dental room as care and treatment was performed. However, we did not observe any areas of concern with their processes. The staff informed us that the clinic was due to move locations to a new site in three months.

Staff demonstrated an awareness of HTM 01-05 (a guidance document released by the Department of Health to promote high standards of infection control) and confirmed that they had access to personal protective equipment to undertake their roles when supporting patients during their treatment.

Monitoring safety and responding to risk

Prior to an operating list beginning at the Powillo Dental Centre the whole team, including the Consultant Anaesthetist, held a team briefing or 'team huddle'. This identified any potential problems pertaining to the patient. Staffing was confirmed and a verbal check list carried out that emergency procedures were in place.

All staff undertook yearly training in Intermediate Life Support techniques and at every team meeting a medical scenario was discussed to facilitate understanding and to highlight any deficiencies in understanding and training needs. At every site we visited there was a range of suitable equipment which included an Automated External Defibrillator, emergency drugs and oxygen available for dealing with medical emergencies. This was in line with the Resuscitation UK guidelines. The emergency drugs were all in date and stored securely, with emergency oxygen, in a central location known to all staff. This meant that the risk to patients' during dental procedures was reduced and patients were treated in a safe and secure way.

At each site we visited we were shown a well maintained radiation protection file. This contained all the necessary documentation pertaining to the maintenance of the x-ray equipment. It also included critical examination packs for each x-ray set along with the three yearly maintenance logs. A copy of the local rules was displayed with each x-ray set. The clinical records we saw showed that dental x-rays were justified, reported on and quality assured every time. This meant that the practice was acting in accordance with national radiological guidelines. The measures described meant that patients and staff were protected from unnecessary exposure to radiation.

Anticipation and planning

There were systems and processes in place to identify and plan for patient safety issues in advance and included any potential staffing and clinic capacity issues. The majority of staff we spoke with reported that they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety. The central log for mandatory training confirmed that nearly all staff working in the clinics had attended the required mandatory training.

Other services: Community dental services

All staff underwent yearly training in Intermediate Life Support techniques. At the Poswillo clinic team meeting a medical scenario was discussed to facilitate understanding and to highlight any deficiencies in understanding and training needs. This training was supplemented by an anaesthetist led training session on a six monthly basis to update staff on new drugs, techniques and other advances in anaesthesia. The interchange of staff between Portsmouth and Southampton facilitated all staff to experience different ways of working and update training delivered by the anaesthetists.

Staff demonstrated a good understanding of the diverse needs of patients using the dental service. We observed in all the clinics that sufficient time was allocated for assessment and treatment in response to the complex needs of patients. We found that staffing levels and skills mix, supported safe practice.

Are community dental services effective? (for example, treatment is effective)

Evidence-based guidance

The senior management team reported that key information from the clinical networks they attended was shared with staff across the service following the production of guidance. The service had a number of clinical leads who ensured best practice guidelines were implemented and maintained.These included leads in general anaesthesia and sedation, special care dentistry and occasional care

Domiciliary dental care was provided across the sector using the standards set out in the Guidelines for Domiciliary Care by the British Society for Disability and Oral Health (BSDOH). We observed an example of the clinical records of a patient who had received domiciliary care from a Senior Dental Officer. Detailed clinical records included a risk assessment of the patient's home to check if it was a suitable environment for undertaking clinical care. Also a written medical and drug history, a Mental Capacity Act assessment and a record of the clinical intervention. Where possible the records were transferred to the dental computer software system as soon as possible following the visit. This enabled follow up care to be provided by another clinician in the event of staff annual leave or sickness. This evidence was in line with best practice guidelines as set out in the guidelines described in the BSDOH document.

Dental general anaesthesia (GA) and conscious sedation was delivered according to the standards set out by Royal College of Anaesthetists and the Department of Health Standing Committee Guidelines in Conscious Sedation 2003. This was confirmed by observing a theatre session at the Poswillo Centre. The GA and sedation care was prescribed using an approved care pathway approach. Patients enter a recognised pathway of: Tender Loving Care (TLC), TLC and inhalation sedation, TLC and intravenous (IV) sedation and finally GA.

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. During our visits we discussed and reviewed patient treatment records. We found details of the condition of the gums and soft tissue lining of the mouth was carried out at each dental health assessment. This meant the patient was made aware of changes in their oral condition. The patients dental recall interval was determined by the dentist using a risk based approach based on current NICE guidelines.

Preventive care across the service was delivered using the Department of Health's 'Delivering Better Oral Health Toolkit 2010'. This was evidenced during direct observation of a treatment session delivered by dental therapist. During the session the therapist used a brief quit smoking intervention as per the toolkit and the Department of Health's guidelines for dental care professionals 'Smoke Free and Smiling' 2014. She also provided tooth brush instruction and optimum fluoride use as per the toolkit's guidelines.

We observed that care provided was evidence based and followed recognisable and approved national guidance such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. Policies reflected national guidance with appropriate evidence and references. Staff we spoke with could direct us to these policies.

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these when delivering care and treatment. For example, we reviewed the records for one patient who had been assessed as lacking capacity to make decisions and for

whom a decision had been made regarding tooth extraction. We saw the appropriate people, including relatives had been involved in the decision making process, involvement of IMCA and that the decision had been clearly documented in the patient's notes and this had been subsequently reviewed and updated.

Monitoring and improvement of outcomes

Staff undertook a number of audits to monitor performance and outcomes. We were shown the service line audit plans which were determined through discussion with clinical leads and agreed by the clinical director and operations director. For example the dental service performed an audit to ascertain whether NICE guidelines were being followed within the service with respect to recall period by verifying the existence of a recorded recall interval within the patient record. The results of the audit found they were meeting this standard and recording appropriately.

The quarterly patient satisfaction survey results we viewed demonstrated a high level of satisfaction with the service patients received from the staff.

Staffing, equipment and facilities

The Department of Health's expectation in dentistry (A review into NHS Dentistry-The Steele Review 2009) is that dental services should use skill mix in the provision of high quality dental care for patients. The dental services in Solent were meeting this expectation by the deployment of effective skill mix throughout the whole service. We saw that dental nurses in the clinics we visited had undergone further training in dental radiography, fluoride varnish applications, oral health promotion and impression taking.

There was also extensive use of dental therapists throughout the service. Dental therapists could undertake a range of treatments including fillings for both children and adults and the extraction of children's primary teeth. The use of extended duty dental nurses and dental therapists enabled the dentists working in the service to concentrate on diagnosis and treatment planning and the delivery of more complex care. This included intra-venous sedation, treatment under general anaesthesia and treating patients with complex medical histories such as patients with long term conditions such as dementia, blood disorders and complex physical and mental impairment. These patients often are taking a cocktail of different drugs which can compromise the delivery of safe effective dental care.

We observed during the delivery of general anaesthesia how enhanced duty dental nurses had been trained to effectively provide the same level of care during the recovery phase of a patient as a trained operating department practitioner. Because the service adopted flexible working staff could move around different locations to assist at times of staff shortages. For example if there is staff sickness or annual leave. We saw at two of the clinic locations that a therapist stepped in to cover for a dental nurse at another clinic. This minimised disruption for the patients in that clinic did not have to be cancelled. Also cross location working facilitated the spread of new and effective ways of working and spread of best practice.

Staff across the service told us there was good access to mandatory training study days and profession specific training. In each of the areas the team manager held a monthly staff meeting. A variety of topics were discussed at these sessions included safeguarding issues, infection prevention and control, moving and handling, medicines management and health and safety. Staff told us they felt the agenda was appropriate. Mandatory training attendances as recorded by the provider in January 2014 showed overall an average of 96% of staff had met their training requirements in the dental service. This meant staff had the right skills, experience and support to deliver safe efficient care.

Multidisciplinary working and support

The service was relatively self-contained because the department contains a diverse mix of well trained and experienced dental staff. However the nature of the patients and their special needs required multidisciplinary working. For example patients would often present with complex medical conditions requiring consultation with the patient's GP. One example was where a patient required a general anaesthetic confirmed at the very last moment that they were suffering from chronic liver disease. This required urgent collaboration with the patients' GP before the treatment could be provided.

Multidisciplinary working was also evident at the Poswillo Centre where close collaboration between the dental team and the Department of Anaesthetics at the Queen Alexandra Hospital for the safe provision of general anaesthesia for dental patients. Other examples included

multidisciplinary working between the children's safeguarding team, social services and school nursing when issues had been highlighted by the dental team in potential child abuse cases.

We observed, and staff we spoke with told us, that there was effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Effective MDT meetings, which involved dental staff, social workers, safeguarding leads, where required, ensured the patient's needs were fully explored. This was evident when we spoke with the safeguarding lead for the service.

Issues discussed at the meetings included identification of the patients existing care and treatment needs, relevant social / family issues, mental capacity as well as any support needed from other providers on discharge home. We were shown evidence of the outcomes of these meetings in patient's files. We observed staff working well together respecting each other's contribution into the planning and delivery of patient care.

Electronic patient records that detailed current care needs were available for all patients ensuring staff were fully informed of the patient's diagnosis and current physical and emotional needs and treatment plans.

Are community dental services caring?

Compassion, kindness, dignity and respect

We observed all staff treating people with dignity and respect and taking extra time with patients who didn't have full capacity to fully understand the advice being given. We observed a treatment session at one clinic how the dentist built and maintained respectful and trusting relationships with patients and their parents and carers. The dentist sought the views of the patient regarding the proposed treatment even though some of the patients were young children. All the patients we observed were given choices and options with respect to their dental treatment in language that they could understand. They were treated with respect and dignity at all times.

Staff told us that effective communication and collaboration between all members of the multidisciplinary team ensured trust and respect in those delivering prescribed treatment and care.

Patients, their relatives and carer's were all positive about the care and treatment they had received from the dental team. Patients told us that staff were very good at dealing with dentistry phobia and they felt very safe with the staff.

During direct observation of patient treatment across a number of clinics it was evident patients, of all ages, were treated with kindness, dignity and respect within a safe and caring environment. The patients seen at the Poswillo Centre were treated within a consultant led service which gave patients and their parents and carers confidence that they would receive safe and effective care. The receptionist on duty ensured all of the pre and post-operative instructions were understood by the parents, carers and the patient themselves if they had the capacity to do so.

The receptionist was able to provide reassurance if delays to the procedure occurred. We observed that the induction process for the anaesthetic was carried out in a calm and caring way ensuring the patient and their parents and carers had a positive experience of general anaesthesia going forward. The surgery itself was unhurried and the recovery from the anaesthetic especially for the very young child was facilitated in a very caring way by dental nurses responsible for recovery.

We observed staff treating people with compassion, empathy and respecting each patient individually. For example, where a member of staff was reassuring a child and their parents about the discharge home following their general anaesthetic. The child's notes recorded the assessment prior to them leaving the unit and that they were able to walk unaided. The child was distressed at waking from the anaesthetic but assured by the dental nurses calm approach. The parents questions were answered fully and they were given an out of hour's telephone number in case of any concerns once the clinic was closed.

Informed decisions

Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. We found that planned care was consistent with best practice as set down by national guidelines.

Observation of practice and review of patient records evidenced that staff were assessing the patient's capacity

to be able to give valid consent using the Mental Capacity Act (MCA). We found that relatives and/or the patient's representative were involved in discussions around the care and treatment where it was appropriate.

Staff had a good understanding of consent and applied this knowledge when delivering care to patients. Staff we spoke with had received training around consent and had the appropriate skills and knowledge to seek consent from patients or their representatives. We observed positive interactions between staff, patients and/or their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care being delivered.

A range of literature was available for patients, relatives and/or their representatives and provided information in regards to their involvement in care delivery from the time of admission through to discharge from the general anaesthetic clinic. This included: complaints processes, key contacts information and follow-up advice for when the patient left the centre.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. We observed positive interactions between staff and patients, where staff knew the patients very well and had built up a good rapport. We saw staff providing reassurance and comfort, for example at Poswillo Centre especially during the recovery phase of young children who had undergone a general anaesthetic. For a very young child the initial stages of recovery can be very distressing because they can be very disorientated and their parents may not be present. This requires the recovery nurses to be sensitive to a child's emotional needs at this point in recovery.

We observed four young patients at this stage; they were well supported by the recovery dental nurses until the child was ready to be re-united with their parents. We observed how kind and caring the nurses were with the child and this continued right up to the point of discharge from the Poswillo Centre. The receptionist on duty also played her role in providing reassurance to the parents whilst the child was undergoing the procedure. We saw on our visit one such occasion which the receptionist dealt with in a very sensitive and caring way.

Parents told us how the staff had worked with their children to reassure them of the clinic, its staff and the equipment. The parents said "I was so anxious about bringing them today and never thought we would get them through the door. But it's worked and they are fine. That is down to the staff who had been so patient with them and took time."

Are community dental services responsive to people's needs?
(for example, to feedback?)

Meeting people's needs

The service had, over a period of years, moved from a traditional Community Dental Service to one which is a referral based specialised service. It targeted patients with special needs due to physical, mental, social and medical impairment.

An example of proper planning and funding had been the development of the Poswillo Centre at the QA Hospital. This service had a dedicated suite for providing general anaesthetic services for dental patients appropriate for the acceptance criteria of the service. This included the treatment of very fearful young patients with high treatment needs who had difficulty accessing a primary dental care setting in the high street. All of the patients were seen within national guidelines of 18 weeks, we saw data which showed that the average wait was only 10 weeks. The team manager described how they were able to adjust appointment schedules to accommodate extra patients due to patient cancellations. This demonstrated an efficient use of resources and making effective use of consultant time.

Staff told us how they were meeting the needs of the patients they saw with complex needs. There were good mechanisms for information sharing between the different clinics and referral back to patient's own dentist for those who only used the service occasionally. The staff within the clinics showed a willingness to engage with other service providers, such as the mental health teams and adult social care providers. In one clinic we were told of some patients that cancelled their appointments at the last minute. This could be due to transport issues. The receptionist tried alternative appointments to meet their needs and would ensure this was communicated to the dentist if it happened more than once. The service had in place procedures to deal with repeated non-attendance issues which enabled them to monitor and report any concerns to the local authority.

Other services: Community dental services

Staff were knowledgeable regarding the community in which they provided services and the provided appropriate written information to patients upon referral to the service and at discharge. Staff knew how to obtain support for communicating with patients. For example, a translation service was available if the patient's first language wasn't English.

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). In addition to the mandatory training, staff working within the dental service had received training for caring for patients with dementia and those who displayed challenging behaviour. Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.

Where patients or children lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals. For example, a patient who had been assessed as lacking capacity to make decisions for some dental extractions had involved an Independent Mental Capacity Advocate (IMCA). It had been agreed that the procedure would not go ahead. We saw that the appropriate people, including relatives, had been involved in the decision making process and that the decision had been clearly documented in the patient's notes. This had been subsequently reviewed and updated.

Access to services

The service had a well-defined acceptance criteria and an innovative clinician led single point of access referral system which meant only those patients with special needs were able to access the service. This service was divided into what the service described as 'spec and spoc', which related to the commissioned services for special care and specialist occasional care. The Specialist Occasional Care Service is for patients who only require a single course of treatment and are able to return to their general dental practitioner for continuing dental care in the future. When we visited the Eastleigh Dental clinic we observed that the service endeavours to fit patients in the same day if they are suffering from urgent painful conditions.

It was apparent when discussing the treatment needs of patients with clinicians they were meeting the needs of vulnerable patients of all age groups. One of the Senior Dental officers in Southampton acts as safeguarding lead for the service. This particular clinic is within a Sure Start Centre in an area of social deprivation where there is a high possibility of encountering children who are suffering from dental neglect which is considered a safeguarding concern. The patient electronic record had a 'concerns tab' which clinicians used to capture important details and used to determine if a child is vulnerable to certain criteria which may suggest they are subject to the various types of child abuse.

Some of the details recorded included: a dental trauma card findings, delay in presentation details, behavioural characteristics, presenting injuries and contact details of school nurse or health worker. The findings were then shared with the children's safeguarding team, the school nursing service and social services to determine the way forward for that particular child. We were shown examples of completed 'concern's tabs' to see how it worked in practice.

Another IT based tool was used by clinicians to determine the mental capacity of a patient. We saw examples of this for patients undergoing domiciliary care. A mental capacity assessment tool had been created as a word document which the clinician completed at the first assessment visit. The staff also completed a risk assessment of the person's environment to check the suitability of it for clinical care to take place. We saw examples of completed assessments which were meticulously filled in and complete.

All locations viewed as part of our inspection were fully accessible for people with a physical disability or who required the use of a wheelchair. Accessibility to the clinics we visited were good as some services were provided on the first floor level with lifts and stairs. Car parking was available on site, however, places were limited and at some locations it could be busy at different times of the day.

Care co-ordination

Staff spoken with reported that in a large number of cases patients were referred to the community dental service for

short-term specialised treatment. On completion of treatment, patients were discharged to the patient's own dentist so that ongoing treatment could be resumed by the referring dentist.

Referral systems were in place, should the dental service decide to refer a patient on to other external services such as orthodontic or maxillofacial specialists.

We observed during our visit to the Poswillo Dental Centre patients were discharged from the service in an appropriate, safe and timely manner. The patients were cared for in a very kind and caring way by appropriately trained recovery dental nurses. We observed that during recovery the patients' vital signs were monitored until they were in a proper state for safe discharge. During the discharge process the nurses made sure the patient or responsible adult had a set of written post-operative instructions and understand them fully. They were also given contact details if they require urgent advice and or treatment.

Learning from experiences, concerns and complaints

Staff told us that the provider was open and transparent about complaints and concerns and that they were encouraged to improve or develop services where issues had been raised by patients and their families. The trust's Board meetings include a customer experience report which looked at trends in complaints, compliments, feedback from visits by the executive team and other patient feedback.

Staff were knowledgeable in regards to the processes available to advise patients and relatives about how to make a complaint and aware that a log of all complaints was held on a centralised system. Each of the clinics we visited had an information leaflet for patients and relatives. This contained information about the opening times, contact details out of normal hours and how patients could complain. The service maintained records of any formal complaints received within each service, together with details of the outcomes and any action taken to improve the service. This provided evidence that complaints were listened to and acted on.

Complaints were reported monthly and we were told each area team manager reported to senior managers with the outcome. Staff told us that discussions were held with staff involved in the complainants care and that any issues that were raised by patients outside of the complaints process would be addressed immediately. The organisation also collected feedback from families who used the service and acted upon the results. In one clinic the results were displayed in the waiting area. We found a high level of satisfaction with the service, resulting in very few complaints being made.

Staff told us that local resolution of complaints was preferred and staff were involved in the investigations. A process including defined timescales for investigation and draft response and development of action plans addressing areas of concern identified within the complaint.

Are community dental services well-led?

Vision and strategy

It was evident from discussions with the senior dental management team that the service was well led with a forward thinking and proactive Clinical Director. The Clinical Director had links with the Regional Consultant in Dental Public Health who provided an overview of dentistry for the whole area. The Clinical Director had also built constructive relationships with the commissioners of dental services enabling sustainability and future of the Special Care Dental Service in Solent NHS Trust. The Clinical Director also stated that she had good links with the Local Dental Committee which acts as a conduit between local practitioners and important stakeholders such as NHS England, Health Education England and the dental specialty within Public Health England.

We saw and staff informed us that the value base of the trust was openly discussed as part of the appraisal system. Staff confirmed they understood the vision of the trust and were aware that information on strategic plans for the organisation could be accessed via the trust's intranet.

Staff spoke of how the senior management and their team managers within the service had provided good support and leadership to the service following the merger of the dental service contract in April 2013. The service had three previous providers of special care dentistry within Hampshire. The contract from April 2014 provided a single special care dental service under Solent NHS Trust.

Other services: Community dental services

We observed staff were passionate about working within the service and providing good quality care for patients. We saw evidence of service improvement initiatives and regular monitoring of the quality of the service.

Governance arrangements

We saw that the Board received quality and safety reports every month which included information such as staffing vacancies, numbers of incidents and complaints.

The use of regional team managers appeared to be a good innovation. The team managers were responsible for a group of clinics and would be responsible for all of the local governance arrangements for their group of clinics. They would be responsible for cascading information upwards to the senior dental management team and downwards to the clinicians and other staff on the front line. These team managers would be responsible for the safe implementation of policies and procedures in relation to infection control, radiation used in dentistry, local training and appraisal of dental nurses, dealing with medical emergencies and incident reporting.

Records of checks and audits and discussion with the team managers confirmed a strong commitment to quality assurance and maintaining high standards. We were told that the staff meetings were useful for raising any issues and "helping us improve as a service."

The service had an effective system to regularly assess and monitor the quality of service that patients received. They had developed a system that gathered the views of patients and inform them of any changes they may need to consider.

Leadership and culture

Staff reported to us that they had opportunities to meet with team members, managers and members of the senior management team including the chief executive of the trust. For example, a range of meetings were co-ordinated at different intervals throughout the merger of the service to Solent NHS Trust. This enabled opportunities for staff to communicate and engage and to share and receive information about the trust and the merger.

Staff confirmed that they felt valued in their roles and that managers within the service and trust were approachable, supportive and visible. The majority of staff said there was visible leadership across the organisation and expressed confidence that any concerns raised with senior managers would be acted on.

The staff roles and responsibilities were clearly defined with a sufficient skill mix of staff across all staff grades and all staff spoke of their commitment to ensuring patients were looked after in a caring manner.

It was apparent through discussions with all members of the team that the Clinical Director was a strong and capable leader who was able to 'fight their corner' with the commissioners of dental services which ensured sustainability and progression of the service going forward. During a period of the merger there was a danger of staff redundancies however due to successful negotiations with the commissioners the service was able to secure funding without the need for further redundancies. This this did result in the re-grading of staff to lower grading's to ensure financial sustainability of the service which the staff seemed to have accepted. Clinicians stated that there is an open door policy with respect to the Clinical Director who is always on hand to provide professional support and advice.

The service also benefits from an intermediate system of team leaders whom cover the four sections of the geographical patch. These team leaders provide immediate line management support to all members of the clinic staff and they in turn feed-back to the senior management team.

Acting on feedback

All of the staff we spoke to were very patient focused and provided patient centred care. Clinical Leadership was also evident at a local level with individual clinicians and the local team managers. The service had undertaken a recent patient satisfaction survey which demonstrated a high level of patient satisfaction. The scoring criteria used a score of 4 as the highest level of satisfaction. The service scored an average of 3.9 for all sections of the survey. This fact alone demonstrated that the staff understood the requirements of good care from a patient's perspective which has led in turn to a very low level of patient complaints.

Continuous improvement and innovation

The culture of the service appeared to be that of continuous learning and improvement. All staff had the opportunity to take further qualifications to enhance the patient experience dependant on the outcome of their appraisal and subsequent PDP. Data supplied by Solent Trust showed that the Dental Services was well above the average figure for the percentage of staff within the Trust who had received an appraisal. The team managers

Other services: Community dental services

described how the dental nurses had undergone additional training in dental radiography, fluoride varnish applications, impression taking and oral health promotion which enabled the service to provide enhanced care for patients.

A number of the dentists had additional post graduate degrees and diplomas which enabled the service to provide increasingly complex care to an increasingly complex and diverse patient base. Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner.

Staff reported that they had access to mandatory, ongoing training and continuous professional development opportunities which had been funded by the trust. Training records viewed demonstrated that staff had completed mandatory and other continuous professional development courses and systems were in place to ensure refresher training was undertaken periodically.

This section is primarily information for the provider

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
Treatment of disease, disorder or injury	People were not always able to access sexual health services as waiting times were sometimes long for walk-in clinics and people were at risk of being turned away. Actions taken by the Trust to improve access to the service have not been sufficient. This meant people were not always provided with services that protected their sexual health or treated their sexual health illnesses.The provider had not ensured the planning and delivery of care and treatment to meet people's needs, and to protect their safety and welfare. Regulation 9 (1) (b)(i)(ii)(iii)