

Staffordshire & Stoke-on-Trent Partnership NHS Trust

R1E

Community health services for adults

Quality Report

Staffordshire and Stoke on Trent Partnership NHS
Trust

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
R1EG3	Staffordshire and Stoke on Trent Partnership NHS Trust - HQ	Community health services for adults	ST5 1QG
R1EE4	Cheadle Hospital	Community outpatients and diagnostic services	ST10 1NS
R1E56	Haywood Hospital	Community outpatients and diagnostic services	ST6 7AG
R1EE3	Leek Moorlands Hospital	Community outpatients and diagnostic services	ST13 5BQ







This report describes our judgement of the quality of care provided within this core service by Staffordshire and Stoke on Trent Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Staffordshire and Stoke on Trent Partnership NHS Trust and these are brought together to inform our overall judgement of Staffordshire and Stoke on Trent Partnership NHS Trust

Summary of findings

Ratings

Overall rating for the service	Inadequate	
Are services safe?	Inadequate	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive?	Requires improvement	
Are services well-led?	Inadequate	

Summary of findings

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Summary of findings

Overall summary

Substantial staff shortages meant that patients were at increased risk of avoidable harm. Poor staffing levels in some parts of the service had a significant impact on its ability to provide safe care. Due to these poor staffing levels, uptake of mandatory training was below trust target levels, and documentation, including risk assessments, were not kept consistently up-to-date.

Staff reported incidents and felt supported to do so, but learning was limited and not always shared. Staff understanding of the Duty of Candour regulations was mixed. Not all staff had an understanding of the meaning of Duty of Candour.

Care and treatment reflected current evidence-based practice but there was limited data on outcomes of care for patients. Staff told us they did not have the capacity to collect relevant information.

The service had not met its target on completion of staff appraisals, and access to clinical supervision was limited for nursing staff. Staff said there were opportunities for training and development but demand on services meant that opportunities to attend training were limited.

We observed staff gaining consent to treatment and care verbally but this was not consistently recorded. Staff awareness of the Mental Capacity Act was patchy and the service had not ensured that staff were fully aware of their responsibilities under the legislation.

Although targets had been set for responding to urgent and routine appointments, the service did not routinely collect data on performance against these targets, so it could not determine if it was responding to peoples' needs.

Although staff were clear on the purpose and vision for the service, the values were not widely shared and there was no clear strategy. Staff did not feel supported by senior managers and felt they did not understand the daily challenges staff faced. Community nursing teams showed a strong patient focus, but many staff described a culture of fear and anxiety about the safety of the service. Managers in the service were sighted on a number of challenges facing the service but had not taken effective steps to address them or monitor activity to measure the impact. The delivery of high-quality care was not assured by the leadership, governance and culture of the service. We found there were inconsistencies with effective leadership across adult community services.

People were supported and treated with dignity and respect and they were involved as partners in their care. Feedback from people using services was positive about the way they had been treated by staff.

Summary of findings

Background to the service

Staffordshire and Stoke on Trent Partnership trust provides adult community services to a population of 1.1 million people across a geographical area of around 1,012 square miles. The trust saw patients in community settings two million times during 2014/2015, resulting in almost 20,000 people being able to avoid a hospital stay.

There are 33 Integrated Local Care teams (ILCT) and four out-of-hours teams providing adult community services.

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh OBE FRCP, consultant in medicine for the elderly, East Lancashire Hospitals NHS Trust.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including:

Head of quality; deputy director of nursing; consultant nurse; clinical quality manager, community matrons;

nurse team managers; senior community nurses; occupational therapists; physiotherapists; community children's nurses; school nurses; health visitors; palliative care consultant; palliative care nurse; sexual health nurses.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

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

How we carried out this inspection

We inspected this service in November 2015 as part of the comprehensive inspection programme.

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 3 to 6 November 2015.

We did not hold a public listening event before this inspection as we were looking to assess changes and progress over a defined period of time, however we did contact Staffordshire Healthwatch and Stoke Healthwatch to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of the services.

Summary of findings

We met with the trust executive team collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades.

Before the visit, we held seven focus groups with a range of staff across Staffordshire who worked within the service. 120 staff attended those meetings and shared their views.

We inspected the regulated activities across a number of locations and community nursing teams. Services we

inspected were provided in people's own homes, residential homes and within clinics. We spoke with 86 patients, 13 carers and relatives, and 194 staff across a range of roles within the trust. We looked at 57 sets of patient records.

We carried out an unannounced visit on the evening of Thursday 18 November 2015.

What people who use the provider say

We spoke with 86 patients and their carers during the inspection. All responses were very complimentary about the staff and the care and attention they received.

Patients told us how kind and caring the staff were and how well they understood their needs, and that they were pleased with the service provided.

Patients told us they received excellent care particularly from the occupational therapists and community nurse services. We heard comments such as "the physio team

here are brilliant, I've seen such an improvement in my condition, they always listen to me and answer any questions I have" and "all the staff are very polite and caring".

The trust used the Family and Friends Test as a means of receiving patient and family feedback. The trust target for people who recommended the service was 90%. Information we saw for patients surveys returned between April and September 2015 showed that the trust target was met.

Good practice

Feedback from people using services was positive about the way they had been treated by staff. We observed many interactions between patients and staff and they were consistently respectful and kind. We observed good examples of multidisciplinary team working.

Areas for improvement

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

Action the provider **MUST** take to improve

- Ensure staffing levels in community adult nursing are sufficient to ensure that patients receive safe and effective care in a timely way and that this is continually reviewed using a systematic approach to determining the number of staff and range of skills required.

- Review caseloads and workloads of staff in the community adult teams to ensure that the significant issues that threatened the delivery of safe and effective care are addressed and mitigated.
- Review arrangements for handover between teams to ensure this is effective and staff are able to manage the risks to people using services.

Summary of findings

- Monitor response times to urgent and routine appointments within community adults services and monitor the number and frequency of cancelled appointments to ensure patients receive care in a timely manner.
- Ensure that policies and procedures in relation to Duty of Candour support a culture of openness and transparency and all staff have received appropriate training and there arrangements in place to support staff involved in a Duty of Candour incident.
- Ensure that all staff are up to date with their mandatory training requirements and that compliance is monitored on a regular basis to ensure compliance is maintained.
- Ensure that all staff have regular access to appraisals in order for them to develop their skills and competency.
- Ensure that learning from patient incidents and complaints is shared and that all identified actions are followed up to minimise the likelihood of reoccurrence and improve care.
- Review arrangements for compliance with the MCA and improve staff competence to discharge their responsibilities under the Act.

- Ensure a strong leadership focus on the challenges faced in delivering care with a consistent response to staff concerns.

Action the provider SHOULD take to improve

- Review the quality of record keeping in adult community services to ensure patients records are maintained to ensure risks are managed.
- Review the process for completing Root Cause Analysis investigations to ensure they consistent and an action plan is developed.
- Improve access to clinical policies for staff working away from base.
- Increase visibility of senior leaders amongst front line staff groups.
- More effectively engage and support staff in proposed changes to service configuration and their role within the service.
- Review and improve storage of medicines to ensure they are appropriately and safely stored.

Staffordshire & Stoke-on-Trent Partnership NHS Trust

Community health services for adults

Detailed findings from this inspection

Inadequate 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as inadequate for safe: This is because:

- The system for assessing staffing levels was ineffective, there were substantial staff shortages affecting the ability to provide care. Demand for community nursing visits routinely outstripped capacity with visits regularly postponed or cancelled. Staff routinely worked extra hours to meet patient needs.
- Systems for handover from one shift to another in East Staffordshire were inadequate and did not allow proper transfer of information between clinical teams.
- Staff understanding of the Duty of Candour regulations was mixed. Uptake of mandatory training was well below trust target levels due to low staffing
- The quality of documentation was variable. The service did not keep documentation, including risk assessments, consistently up-to-date.

- We saw poor storage of medicines in one area. Security of medicines in one location required attention.
- Staff reported incidents and felt supported to do so, but learning was limited and not always shared.

Safety performance

- The trust completed information for the National Safety Thermometer. This is a way of measuring indicators of good care, the level of harm people suffer while in healthcare organisations, and the improvements an organisation makes to ensure people are 'harm free'. The actual numbers of harm identified at the trust fluctuated. From 1 July 2014 to 31 July 2015, community nursing saw a monthly average of 32 pressure ulcers, 11 falls with harm, and nine urinary and catheter infections.
- The trust had a pressure ulcer review group that reviewed pressure area concerns (risks of patients developing pressure ulcers) and incidents. They looked at any themes from incidents to identify what interventions could be put in place to prevent or reduce

Are services safe?

the numbers. Any member of staff was able to attend these meetings. Two community nurses we spoke with who had attended meetings described how they had fed back information to their teams.

- In all the community nursing bases we visited, we saw no information about the teams' pressure ulcer, fall or infection rates. Community nurses were able to tell us about some cases of issues such as pressure ulcers but were unsure about the teams' total numbers of patient harm.

Incident reporting, learning and improvement

- There were no never events reported in the previous year by the trust. Never events are serious, wholly preventable patient safety incidents that should not happen if the available preventative measures have been put in place.
- From 1 September 2014 to 7 August 2015, the service reported 185 serious incidents that required investigation. These involved 170 grade 3 pressure ulcers, 12 grade 4 pressure ulcers, one drug incident (in relation to insulin), one unexpected death of a patient (while not receiving care) and one safeguarding vulnerable adult incident.
- All staff we spoke with stated that they felt confident to report incidents and were able to access incident reporting systems. The trust used an electronic incident reporting system. Staff told us that the system acknowledged when incidents had been submitted.
- It was trust policy that staff should raise an incident for all patient visits they were unable to carry out during their shift. Staff told us that if they had not completed their visits it was usually because they ran out of time and would, therefore, not be able to complete the relevant paperwork either.
- We reviewed a sample of investigation reports submitted by staff and saw root cause analyses (RCA) had been carried out as part of the investigation process.
- We looked at 86 RCA investigations, the vast majority relating to grade 3 and grade 4 pressure ulcers. We found inconsistencies within the investigations. Some investigation reports did not offer an opinion as to

whether the pressure ulcer was avoidable or not, and some did not have an action plan following the incident. This meant that valuable lessons to develop patient safety were not learnt and could not be shared.

- For example, one investigation identified that the person did not have a visit from a qualified community nurse for five weeks and developed a grade three pressure ulcer. The action plan identified that the team would look at ways of ensuring patient visits were not missed, but there were no actions to say how this would be done. We also noted that several patients who had developed pressure ulcers lacked mental capacity to make their own decisions. The investigation reports did not always show that staff had explained to the person, (despite their lack of capacity) or their relatives or carers about risk of skin damage and how it could be reduced.
- There was an inconsistent approach to the reporting and grading of harm. We reviewed incidents and the associated audit trail at one community nursing location. We saw that five incidents between July and October 2015 had been responded to by the team leader. The audit trail demonstrated that no other line manager or risk staff had reviewed the incidents. On two occasions, staff from the risk management team reviewed the incident and had downgraded it from moderate to no harm after being graded by clinical staff. We did not identify from the records that any further investigation had taken place.
- Most staff received feedback from their immediate manager regarding any incidents raised. An member of clinical staff at Hanley Medical Centre showed us an example of an incident report they had submitted, together with the feedback they had received. They told us they regularly received feedback on incidents.
- However, they told us that the feedback often consisted of the advice that the matter had been escalated to senior managers. Staff reported that they rarely received feedback from higher than their immediate manager. Another member of staff showed us more than 100 incident forms that they had completed regarding community nurse workload, going back over 12 months. They had received feedback from her immediate manager saying they would be escalated, but rarely had feedback from higher levels of management. We saw

Are services safe?

four incident forms submitted since July 2015 regarding staffing that had no action or feedback given. One nurse told us the lack of response made her reluctant to report incidents as she felt nothing was ever done.

- Area managers received a monthly report on all incidents that had been reported in their region, which allowed them to maintain an awareness of risks and to identify any trends. We were shown copies of the previous six months' reports, which contained information on numbers and types of incidents reported each month, together with trends, and a breakdown of incidents by locations and teams. They also included details of any patient safety alerts issued by the Department of Health's Central Alerting System.
- A band 6 community nurse in the North division told us that reports of pressure ulcers were referred to the tissue viability team and team leader, but that any RCAs were not shared with the person making the report and the only feedback they received was an email stating 'incident closed'.
- Managers told us themes from incidents were discussed at regular team meetings, and heads of geographical areas attended professional lead meetings to share learning from incidents. We saw minutes that confirmed incidents and learning were discussed as a standing agenda item.
- One community nursing team had not had a team meeting since July 2015 due to low staffing numbers. The manager told us she ensured key messages that should have been discussed in team meetings were discussed at handovers which took place each day.
- Staff told us that incidents and learning from incidents were discussed during staff handovers or team meetings. However, staff did tell us that not all teams had regular team meetings so this information wasn't always shared. We found that staff were unclear in the Stafford teams (Greyfriars) why unqualified staff should no longer undertake equipment checks, review patients' skin (for possible skin damage) and update risk assessments. All of these were changes to practice resulting from learning from incidents.

- We saw alerts circulated around community nursing teams from outside organisations such as the Medicines and Healthcare Products Agency (MHRA), alerting nurses to incidents that had happened in other organisations.

Duty of Candour

- There was mixed understanding among community staff (therapists, community nurses and community intervention service staff) about 'Duty of Candour'. Some staff (including a team manager) told us it related to a complaint, and if mistakes had been made an apology was given. Other staff did not understand or recognise 'Duty of Candour', but when we asked what they would do if they made a mistake, they told us that they would give an apology when needed. Four staff, at three locations, from bands 3, 5 and 6, told us that Duty of Candour meant "apologising without admitting liability".
- We asked staff if they had received training in the 'Duty of Candour' but all staff we asked said they had not received this training. One team leader told us they had received an email that week that included information about Duty of Candour.
- A band 7 team leader told us that incident reports were assessed by the trust's risk team and were forwarded to the team leader flagged as 'Duty of Candour' if the risk team judged that it was applicable. However, the team leader was not able to demonstrate a good understanding of their responsibilities under Duty of Candour. We were not reassured that Duty of Candour was being properly applied.

Safeguarding

- Safeguarding level 1 for adults training was one of the 10 mandatory training courses for staff. Seventy-nine per cent of adult community staff had completed training (levels 1 to 3) compared with the trust's target of 90%. Eighty-one per cent had completed safeguarding children training at level one.
- Staff told us that they had safeguarding (adults and children) training as part of their initial induction followed by annual updates. Some staff told us they thought that safeguarding training undertaken as part of

Are services safe?

their induction was level 1 and that further training was level 2 and 3. The service had not completed an analysis of training needs for safeguarding to determine which staff should be trained to which level.

- Staff we spoke with were aware of their responsibility to keep people safe and, when needed, report any safeguarding concerns they had. All of the staff that we spoke with were able to give examples of when either they or a member of their team had made a safeguarding vulnerable adult referral and actions taken to keep people safe. They told us they felt supported by their immediate line managers with safeguarding issues, and had attended multidisciplinary meetings to discuss safeguarding concerns with particular patients.
- Staff at all locations demonstrated a good understanding of when and how safeguarding referrals should be made; however, they told us they had very limited feedback on referrals they made and rarely heard anything at all.
- Between April and September 2015 staff in the North division reported 33 safeguarding incidents, most of which were about the protection of vulnerable adults.

Medicines

- At most of the locations we visited, medicines were stored safely and checked regularly. However, at one location we found injectable medicines were kept in a filing cabinet. Although this was kept locked this was not a suitable storage place for these medicines. When we raised this issue with the trust pharmacy team, they were not aware that this particular clinic stored any medication and, therefore, it had not been subjected to safety checks. The storage was not in line with the trust's medication policy and the pharmacy team undertook to resolve the issue. We were told by the Chief Executive that an immediate short term safety solution had been implemented following our inspection whilst awaiting the erection of a secure medicines cabinet.
- Some medicines such as those used for relief from pain are 'controlled medicines' and may require additional storage, administration and disposal arrangements. We visited one person who had a syringe driver in place which was administering medication for pain relief. We saw that the person had their own medicines securely stored. We saw that the community nurse checked the

amount of medicine that was left and recorded this before setting up the syringe driver. We observed that the controlled medicine was appropriately administered and syringes were appropriately disposed of.

- We accompanied community nurses on visits to patients' homes and found that medicines were administered safely and appropriately. We also noted that community nurses completed a record of each medicine they administered.
- We observed correct disposal of sharps in all locations we visited.
- We saw that community nurses completed a record of each medicine they administered. We observed a community nurse (from Uttroter community nurses) explain to a person that they had been prescribed their medicine three times a day and they would ring them later to check if they needed a further dose. We saw when the same community nurse visited another person who had recently been discharged from hospital, they spent time to check the patients understanding of what the medicine had been prescribed, and how often they should have it. We saw this was good practice to ensure that medicines were safely administered and people were protected from potential harm.
- At Haywood community hospital, we were told that out of hours access to the pharmacy was not adequately controlled. We were told that access was gained using a swipe card but that the cards worked 24 hours a day, seven days a week. Access was limited to pharmacy staff but could not be restricted outside the department's normal operating hours, despite requests to change this having been made by a manager. This meant that security of medicines could not be guaranteed. The trust's chief executive was informed of this situation before we completed our inspection, and undertook to improve security.
- Staff at Haywood also told us that when they had started working at the hospital they had found that there was no record of medicine safety alerts and the results of national audits being actioned. They said that the pharmacy staff were willing to learn and change to make improvements and that while they were still not up to date with current practice, good progress was being made.

Environment and equipment

Are services safe?

- Patients were seen in a wide variety of locations throughout the trust ranging from health centres, residential homes and in their own homes. Equipment we looked at such as specialist pressure relieving mattresses (in patients' homes) and syringe drivers in clinics had been appropriately calibrated and maintained and had received required safety checks.
- Nursing and therapy staff in the South division told us that they were able to request equipment for patients such as hospital beds, pressure relieving mattresses and commodes and it was received in a timely manner.
- Staff in the North division also told us that they were able to request equipment for patients. Once ordered, equipment was usually delivered efficiently; however, there were sometimes delays in patient equipment for home use due to work pressures on community nurses; this meant patients did not access equipment to support living at home in a timely way. One nurse told us she hadn't placed an order for a pressure mattress that had been requested the week before by a GP as she hadn't had time. She said that her immediate manager was aware of equipment requesting delays due to time constraints. Nurses had to request equipment using an online system.
- We found out of date blood sample bottles and swabs in equipment trolleys in the clean utility room at Cheadle Community Hospital. We brought these to the attention of the department manager who removed them.
- We found out of date consumable items (sample pots, endometrial cell sample kits, swab sample packets and ring pessaries) and 0.9% sodium chloride flushes (used to clean out intravenous catheters) in an outpatients department consulting rooms at Leek Moorlands Community Hospital. We brought these to the attention of the nurse in charge at the time of our inspection.
- At Leek Moorlands Community Hospital, we found a nebuliser (a machine for delivering medication as a vapour) and a thermometer that were past their service dates. We raised this with the hospital manager at the time and both pieces of equipment were removed from use.
- The entrance lobby at Haywood Community Hospital, which runs clinics for patients with arthritis and other musculoskeletal problems, did not have an anti-slip floor. Anti-slip flooring was provided in the outpatients waiting area however, patients had to cross the lobby floor before reaching it and on leaving the hospital. One fall, by a member of staff, had been reported in this area during August 2015. The staff member was not injured and, at the time of our inspection, the incident report said 'waiting for manager's form'.
- Emergency trolleys at all the community hospitals we visited contained equipment for basic life support and treatment of anaphylaxis (a severe, life-threatening allergic reaction). We inspected trolleys in five locations and found that regular checks were recorded and all of the consumable items and medicines were in date.
- Community nursing staff working at Anglesey House Burton said that there was not enough working office space available. They told us that there were 21 staff but the rooms were only designed to have eight people in one room and four people in the other. This compromised staff safety.

Quality of records

- Record keeping was inconsistent and variable. In some areas, we found that records were complete, detailed records of visits and of care and treatment. For example, at Hanley Medical Centre, we looked at five therapy care plans and found they were all completed to a high standard. They included goal-oriented holistic patient assessments and properly completed risk assessments. However, in other areas records were out of date and difficult to read.
- We reviewed 20 patient records in the South division, some in patients' homes and others which were at the community bases. Records were carbon copied. Staff told us that one copy should be removed and taken back to the community base to file within the patients notes there and the other copy was left in the patient's home. We observed that in at least eight of the records we looked at the carbon copies or copied sheets were not legible. Staff were not able to rely on this information to support their care and treatment decisions as they could not read it.
- Staff were inconsistent in their views on which copy should go where. Some staff told us the top copy was left in patients homes and the bottom copy was kept in the patient's file in the community base, whereas other staff told us it was the other way around.

Are services safe?

- Community nurse records we looked at included initial assessments, care plans, risk assessments and a summary of the visit and care provided. We saw that an assessment of the patient's needs had consistently been undertaken and care plans were in place to meet identified needs. We observed in several care plans that there was no date for the care to be reviewed or an evaluation of the patients care needs. One community nurse told us that the evaluation of the care was included on a day-to-day basis but it was difficult to identify current and on-going care needs.
- We saw that staff completion of risk assessments such as pressure ulcer and nutrition risk was variable. Risk assessments were not always completed or had been reviewed.
- We observed that some care plans had not been reviewed for a significant time, one since 2013, another patient that had not been reviewed following an episode in hospital. This meant that the patient may not have been receiving treatment relevant to their needs.
- Community nurses reported difficulty in completing documentation due to workload pressures. We met one nurse working on her day off to try and catch up with the records of a patient she had visited earlier that week. One patient had been seen four days previously but the nurse had not had time to complete a care plan. The patient was being seen daily so she had to give verbal instructions to her colleagues that visited the patient on the plan of care as nothing had been documented. This meant that errors could happen because staff might misunderstand or confuse instructions for one patient with those of another and have no written record to refer back to.
- We observed at Greyfriars Stafford that boxes containing patient files were not securely locked away. This meant the service was not storing patients personal information in a confidential way. In excess of 36 boxes were being stored in staff corridors and in an unlocked meeting room. We highlighted this to the trust during our inspection. The trust told us that all boxes had been moved into the meeting room which was now locked with restricted staff access and would not be used until more suitable storage could be found.
- There was a clear infection control policy in place and the majority of staff followed the policy.
- Staff in community settings demonstrated good infection control practices such as the use of personal protective equipment and regular hand washing pre and post-patient care. However, we observed a team handover in Stafford when several staff wore jewelled rings and other jewellery. In addition, we observed a member of staff who did not remove their coat when they visited a patient.
- We saw that hand gel was available in clinics and community nurse bases and we observed it being used correctly. We saw used equipment and dressings being properly disposed of in sharps bins and clinical waste bags. Community staff carried soap-based 'handwash packs' as well as alcohol gel, to allow them to carry out effective handwashing while away from their base.
- All of the clinical environments we visited were visibly clean and dust free.
- We observed staff appropriately cleaned equipment when it had been used. For example, we saw that therapists and podiatrists cleaned the examination couch or chair between each patient and community nurses cleaned equipment used to take patients' blood pressure, and thermometers. Charts were ticked every time a cubicle had been cleaned to identify it was ready for the next patient.
- We saw used dressings and needles were appropriately and safely disposed.
- Staff told us that each team had an infection control link nurse. The link nurse's role included attending infection control meetings and providing feedback to their team.
- In the outpatients department waiting area at Haywood Community Hospital there were no posters or information leaflets displayed giving information for relatives and patients about hand cleaning. There were no antibacterial alcohol gel dispensers, fixed or freestanding, available for patients or relatives to use on entering and leaving the department. We asked two staff nurses about the use of alcohol gel in the department and they told us that they didn't have any there.

Cleanliness, infection control and hygiene

Are services safe?

- All of the clinic rooms at Haywood Community Hospital had handwash sinks, soap and alcohol gel available. We saw staff carrying out hand cleaning in accordance with the WHO 'five moments for hand hygiene' guidelines.
- At Leek Moorlands Community Hospital's outpatients department, all of the nine consulting rooms were visibly clean; however, none had a cleaning schedule displayed. The nurse in charge told us that cleaning records were held in a ring binder however when they checked the folder none of the cleaning records had been updated since January 2015. The outpatients waiting area did not have any hand hygiene signs or posters displayed and alcohol gel dispensers were not prominently displayed.

Mandatory training

- The trust had 10 mandatory staff training courses with a target that 90% of staff should have completed this training. Information provided by the trust showed that required compliance with mandatory training was below target overall at 82% against all 10 mandatory course for adult community services as follows:
- Infection control (three yearly) 82%
- Safeguarding adults level 1 to 3 (three yearly) 79%
- Safeguarding children (three yearly) 81%
- Equality, diversity and human rights (three yearly) 82%
- Fire safety (annually) 75%
- Health and safety (three yearly) 83%
- Information governance training (annually) 74%
- Manual Handling (three yearly) 85%
- Basic life support (annually) 67%
- Conflict resolution (three yearly) 79%
- Staff reported the reason for low compliance was staffing shortages. A community nurse at Greyfriars said that all mandatory training was cancelled during August due to staff sickness and annual leave and staff at Leek Moorlands Community Hospital told us that they were unable to complete their mandatory training due to staff shortages.
- Team leaders in Burton and Uttoxeter told us due to staffing difficulties and location of the training it was

sometimes difficult for their staff to attend training. We were told that some practical mandatory training such as moving and handling and fire safety were in North Staffordshire and Cannock which was could be a round trip of 100 miles.

Assessing and responding to patient risk

- Community based staff demonstrated awareness of key risks to patients such as urgency of patient visits and arrangements for further support when required, such as the supply of additional equipment. Patients were assessed under a red-amber-green (RAG) rating system according to their individual needs.
- Community teams told us that they saw patients as soon as possible after a referral. First assessment appointments were prioritised based on individual risk and patient need. Staff told us that urgent cases would be seen within a few hours, less urgent first appointments would be seen within a few days.
- Risk assessments for falls, nutrition and moving and handling were completed but the frequency they required review was unclear. For example, risk assessments from two community nursing teams for falls, manual handling and nutrition had not been updated for a significant time: some for over a year instead of every three months. Staff told us this was because of staff shortages and insufficient time to review records at patients' homes however, we saw regular and up-to-date risk assessments carried out by the occupational therapy, community intervention service and physiotherapy teams which reflected patient's needs.
- We observed a community nursing team handover at three locations. We saw that concerns were identified between team members and escalated appropriately. Staff demonstrated confidence in being able to escalate their concerns about deteriorating patients. Senior clinical staff provided advice and capacity in the team to respond to the needs of vulnerable patients.
- Community nurses in East Staffordshire told us, and we observed this during our unannounced visit that there was no handover between day and evening staff and night and day staff. Details of required visits were left on an answerphone as there was no overlap between the shifts. Staff raised concerns about this arrangement as there was no opportunity to clarify any patient

Are services safe?

information such as their address, or how staff might gain access. One nurse we spoke with told us that one day they had a message (from a receptionist) to visit a patient who required end of life care and required a syringe driver but no details were given about what medicines were needed or the patient's diagnosis.

Staffing levels and caseload

- Staffing levels in the community nursing teams were assessed using the trust's workforce planning tool, through which data on activity was collected over a period of time to determine the required staffing levels. All community nursing teams were subject to a review of staffing and caseloads during 2014/2015.
- Staff told us that since the planning tool had first been used to assess staffing levels the structure and the activity levels of the community nursing teams had changed. Senior management we spoke with confirmed this and told us there were no immediate plans to re-evaluate staffing levels.
- The workforce planning tool calculated that to provide safe staffing levels, 2,354, community nursing staff were needed. As at July 2015, there were 2,049 staff in the service, including nurses, health care assistants and physiotherapists this meant there were 305 vacancies; which equated to approximately 13% of the workforce.
- Information provided by the trust identified bank staff were used and occasional agency staff were used to cover the shortfall. Team leaders also told us their own staff worked additional hours to cover shifts. Data showed, and we observed during our inspection that shifts went uncovered. Information provided by the trust identified that from January 2015 to August 2015 only between 0.7% and 3.4% of community nursing shifts were filled by bank staff.
- Staff across the trust told us and we observed that they regularly worked over their contracted hours. Some community nurses were managing their caseloads by starting work earlier and finishing later than their rostered duties. They said the service relied on their good will to meet patients' needs. We saw examples of nurses working on their day off to complete work that was not possible in their contracted days.
- Data from the trust showed vacancy rates of 16% for qualified nurses and 28% for healthcare assistants for the North division.
- The trust provided details of the number of vacant shifts not covered by bank or agency staff, for the North community nursing teams during the month of July 2015. 18% of community nursing shifts had not been covered during the month.
- For the six months from April to September 2015, North community nursing teams in carried out 161,575 visits. On the July 2015 staffing levels given to us this meant that, on average, each member of staff had 37 patient visits per week. If the community had been fully staffed this would have reduced to 29 visits per staff member per week. This meant that community nursing staff were actually carrying out over one-quarter more patient visits than planned.
- At Moorlands Medical Centre, we spoke with a group of seven community nurses while they were working through their meal breaks. They told us that working through their breaks was normal practice due to their workload of 17 to 18 visits per day, and that they all normally finished between half an hour and an hour late every shift to complete their administration, but that it could sometimes be up to two hours late.
- At Hanley, we were told that there used to be a team of staff who covered early mornings from 7am, but that they had all retired and had not been replaced. The early morning cover was now shared between four community nursing teams on a rota basis; however, staff who started early and were meant to finish early as a result rarely did so due to the workload and worked extra hours as a result.

South division staffing levels and caseload

- The team leader in Branston and the East Staffordshire night service told us they had long-standing vacancies which had been difficult to fill. Information provided by the trust confirmed that there were three whole time equivalent (WTE) qualified nurse vacancies for Branston community nurses and approximately 5.5 WTE vacancies for the evening service. The team leader for Riverside also told us they had vacancies but new staff had been appointed and had start dates identified.

North division staffing levels and caseload

Are services safe?

- The evening service in East Staffordshire told us there should be two qualified nurses and two health care support workers on duty between 6pm and 11pm. Staff told us and records we looked at confirmed, that there were times that there was just one nurse on duty covering both Uttoxeter and Burton areas.
- We visited the out of hours service during our unannounced inspection and also spoke to staff. The trust told us that for the evening team working from Uttoxeter the staffing requirement was two registered nurses and two healthcare assistants on each shift. During our inspection, we identified that on two shifts (1 and 3 November 2015) there was only one registered nurse on duty.
- A review of previous staffing rotas showed that between June and October 2015 on 50 shifts there was only one registered nurse on duty. This equates to 32% of all evening shifts. Furthermore, the staffing rotas showed that on two occasions during this period there were no registered nurses on duty.
- We told the trust about our concerns regarding the lack of a qualified nurse on night duty for East Staffordshire. The trust told us the required staffing in the current model for the Burton overnight service was one registered nurse and one healthcare assistant on each shift. During our inspection we identified four shifts (1, 2, 3 and 4 November 2015) when no qualified nurse was on duty. Further investigation determined that the previous week, there were also three shifts without a registered nurse on duty (26, 27 and 28 October 2015). A review of previous staffing rotas showed that between May and September 2015, 16 shifts were also without a qualified nurse. This equated to 10% of all night nursing shifts. On these shifts services were provided by healthcare assistants. In response to our concerns, the trust immediately hired an agency nurse for four weeks. The trust have since indicated that this agency nurse will remain in post indefinitely.
- The community nursing teams at Branston, Balance Street and Rising Brook told us that they struggled to undertake all required visits. Several staff members told us that they routinely worked additional hours and through their meal breaks.
- We looked at the team diary for the Rugeley community nursing team and found many staff were working above

and beyond the trust's planned activity levels. The total number of hours staff worked far exceeded what the trust had calculated was required to meet demand in that area.

- Sandy Lane community nursing team had an establishment of 18.56 WTE staff with a 0.4 WTE vacancy. This meant that there should have been adequate numbers of staff to cope with demand. The team maintained records which demonstrated that they had to cancel visits due to lack of staffing capacity. The need or dependency of the patient was measured in time slots of 15 minutes (the higher the dependency, the longer the visit). We saw that for a four-week period from 6 to 27 July 2015, the level of dependencies exceeded those that staff were able to meet it 54% of the time.
- Staffing levels in therapy specialist community intervention services were adequate to meet patient needs and demand. These included physiotherapy, occupational therapy, community intervention service, tissue viability, stroke rehabilitation and integrated pain management services.

Impact on staff and patients

- All community nurses we spoke to told us they ensured that all urgent visits were prioritised and undertaken. However, we were also informed that less urgent or routine appointments were frequently cancelled due to lack of capacity. For example, continence assessment were classed as non-urgent visits, we were told that the wait for these visits was up to six months.
- We asked the trust for data on how many visits were postponed or rearranged but they were not able to provide this as it was not routinely collected. There was no standard operating procedure in place to provide guidance and consistency when cancelling patient visits. There was no system in place to ensure that appointments were not repeatedly cancelled for the same patient, patients were reliant on the nurse recognising their name.
- We were able to review some locally held data. At Sandy Lane the community nurse team cancelled 26 visits on 22 October 2015, this equated to a dependency score of 121. This meant that 5.5 extra nurses would have been needed to meet this demand.

Are services safe?

- At Moorlands Medical Centre a group of seven community nursing staff told us they frequently received emails from the out of hours night cover team asking them not to refer any patients to them as they were short staffed.
- Community nurses told us that staffing levels had been a longstanding problem and they were exhausted. Many staff told us they felt they were “unable to cope with demand”.
- The team leaders told us that the staffing levels were challenging and many worked an additional hour unpaid on every shift to ensure all patient visits were allocated.
- Not all community nursing teams had administration support to help with updating the electronic patient records system. Staff told us they regularly took their laptops home and completed the patient records in their own time, unpaid. Many staff also told us they completed administration tasks and emails at home, unpaid, as they did not have time while at work.
- Low staffing levels in community nursing teams, due to sickness and vacancies, were recorded on the risk register for both the North and South divisions since April 2015. Action was being taken to try to resolve the situation however, the risk was still graded as red at the time of our inspection.
- In November 2014, CQC carried out an unannounced inspection at the trust. The inspection identified that there were staffing shortfalls and recommended a review of staffing levels. In August 2015, the trust provided CQC with an action plan which specified all the actions the trust had taken to address the staffing shortfalls and showed that these had been completed. However, during this inspection in November 2015, staffing shortfalls remained a significant concern
- The trust had a lone working policy in place. Procedures to keep staff safe included use of electronic diaries and a ‘buddy’ system to monitor when staff arrived at and left appointments. Staff would never go straight home from their last appointment of the day without contacting a colleague or returning to their base location. All of the community staff we spoke with in the North division were aware of these procedures and told us they used them and they were effective. Staff knew what action to take if a potential risk to a colleague was identified.
- Community nursing staff all told us they mostly worked alone. Staff told us if potential risks were identified, there was an opportunity for staff to work in pairs. Community nursing staff at Greyfriars, Trentside, and the evening and night service in East Staffordshire out-of-hours team told us they were concerned about lone working arrangements.
- Some community teams told us that informal buddy arrangements such as texting colleagues were in place to check that staff had safely completed their duties. All staff had mobile phones but the mobile signal was variable in many rural locations and they were not always contactable.
- Some staff in the county had lone worker devices which would alert an operator. If the staff member felt vulnerable and at risk they could activate the alert and action could be taken to check the staff member’s wellbeing. Staff working for the night service in East Staffordshire told us they had previously had lone worker devices but they had been taken off them.

Major incident awareness and training

- The trust had a business interruption plan which included arrangements for staff to support patients in extreme cold and snow. The plan identified levels of risk with level four being the highest. The plan included agreed arrangements to hire four-wheel-drive vehicles to enable staff to visit and check vulnerable patients.

Managing anticipated risks

Are services effective?

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

Summary

We have rated this service as requires improvement for effective: This is because:

- There was limited data on outcomes for patients. Staff told us they did not have the capacity to collect relevant information.
- Care and treatment reflected current evidence-based practice, but assessments were not always up-to-date and so the service could not be confident the service applied all evidence-based guidance.
- Therapy services took part in some external audits and benchmarked their services.
- The service had not met its target on completion of staff appraisals, 59% against a target of 90% and access to clinical supervision was limited for nursing staff.
- Staff said there were opportunities for training and development but demand on services meant that opportunities to attend training were limited.
- We observed staff gaining verbal consent for care and treatment, but this was not consistently recorded. Staff awareness of the Mental Capacity Act was patchy.

However, we also saw that:

- There were many good examples of multidisciplinary working.

Evidence based care and treatment

- We saw that the trust had a range of policies based on national good practice and followed national clinical guidelines such as The Royal Marsden manual of clinical nursing procedures. Guidance was available on the trust's intranet and some staff showed us it was readily accessible. However, when staff were away from their base and working in the community, they could not always access the trust's intranet, and so guidelines may not be available to staff at the point of direct patient contact.
- We observed that when administering care and treatment the use of pathways and guidance was

followed by staff. Staff we spoke with understood how National Institute for Health and Care Excellence (NICE) guidance was applied and supported local guidelines. We observed staff providing care to patients and we saw that assessment guidelines were used correctly.

- Specific pathways and guidance were used for long-term conditions such as 'Gold standard' for chronic obstructive pulmonary disease (COPD).
- We were given a copy of a standard 'physiotherapy hip/knee replacement assessment' document that was used by therapists across the trust. Use of a standard document ensured consistency in assessments in different locations and acted as a checklist for therapists during sessions with patients.
- Community therapists used the Keele "StarT Back" screening tool to assess patients with musculoskeletal back pain and plan their treatment.
- The falls assessment team based at Cheadle Community Hospital carried out multifactorial falls risk assessments using a standardised risk tool. This followed NICE guideline CG161: 'Falls in older people: assessing risk and prevention'. However, for other teams, health assessments were not always completed or updated in accordance with trust policy, good practice or national guidelines in areas such as skin integrity, nutrition and falls risk. This meant that the service could not be confident that evidenced-based care was being provided consistently by clinical staff.
- We observed post-operative wound care being carried out for seven patients. The processes and dressings used followed NICE guideline CG74: 'Surgical site infections, prevention and treatment'.
- Musculoskeletal physiotherapy services used flow charts to clearly explain the assessment and treatment pathways for 39 different possible types of pain. This ensured that patients across the trust received the same level of therapy and gave therapists confidence in the treatment pathway they recommended.

Are services effective?

- We saw a nationally recognised pressure ulcer risk assessment tool, the 'Walsall score', being used to identify patients at increased risk of pressure damage. The Walsall score is a tool that is tailored to the community nursing environment.
- Therapists at Cheadle Community Hospital used evidence-based exercise plans to help older patients with falls prevention.

Pain relief

- Patients received effective pain relief and pain management plans were discussed with the patient to ascertain their pain levels and to provide advice and appropriate management.
- We saw a pain management service which comprised of a multidisciplinary team of a physiotherapist, occupational therapist, clinical psychologist and support staff. Patients with chronic pain were referred by GPs for treatment and management. They measured clinical outcomes against national indices which demonstrated an effective service.
- There was an integrated physiotherapy orthopaedic pain service, which also demonstrated good multidisciplinary work to manage patients' pain. We observed the team discussing with a patient the options for the best possible pain relief for their condition.

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST) which is a recognised assessment tool to assess nutritional risk. We saw that a nutritional risk assessment was in place which identified risks to the patient's dietary intake and actions required to ensure they had enough and appropriate food intake.
- Community nurses were able to explain what actions they would take if a patient's MUST score indicated they were at risk. They were able to refer patients to dieticians in their teams for further assessments and treatment.
- We noted that not all nutritional assessments had been updated in a timely way, for example in the Rugeley and Lichfield community nursing teams.

- We observed a community staff nurse inaccurately completing a nutrition assessment; they told us they had not had any training in the completion of this assessment.
- We saw in nursing and residential homes senior community staff had provided advice to staff in relation to the management of patients where fluid or dietary intake was compromised.

Technology and telemedicine

- Community nurses told us about their frustrations and limitations of the current IT system. Some community nurses told us they had been provided with laptops. However, community nursing staff in Greyfriars told us there were insufficient facilities for them to use their laptop computers whilst in the community nursing base. Community nurses working for the out of hours service (North Staffordshire) said although they had laptops they were not able to update information whilst in their car in the dark and still had to return to the community nursing base to update patients records.
- Community matrons were able to arrange for patients to use 'telemedicine' in their homes (telemedicine is a system that records and stores patients' observations electronically so they are available to health professionals to review and monitor the patient's health). We looked at the records of one patient who had telemedicine to manage a long-term condition. We saw that the patient or their carers checked and recorded observations such as temperature, pulse, blood pressure and respiration rate on identified days or if they felt unwell. The observations were then submitted electronically to the community matron for review. If needed, the community matron would contact or visit the patient and provide further advice to manage their condition. The use of this equipment meant that the community matron and nurses were able to support the patient's wish to remain at home.

Patient outcomes

- The trust did not achieve 27 of the 111 Key Performance Indicator (KPI) targets for adult community services in 2014/15 that it was measuring. Those it did not meet included intermediate care readmission rate (19%

Are services effective?

against a target of less than 5%); urgent referrals contacted within one hour (25% against a 100% target) and routine referrals contacted within 48 hours (72% against a target of 100%).

- The trust hit all the Clinical Quality Indicators (CQUINs) except for two which were not achieved (Safety Thermometer - reduction in pressure ulcers, and Seven Day Services), and two which were partially achieved. The trust hit all their targets in their Quality Account apart from 12, which were not met and two which were partially met.
- Community therapy services used a standardised questionnaire to assess the effectiveness of treatment provided for patients. The questionnaire was completed and results assessed each time a patient was seen by a therapist. For 2014/15, out of 300 patients, 86% experienced an improvement in their condition following physiotherapy. The physiotherapy and orthopaedic medicine musculoskeletal service reported that out of 52 responses, 52% found the treatment very helpful and 41% helpful.
- Therapists at Cheadle Community Hospital used the Tinetti Gait and Balance assessment tool to measure changes in patients' mobility. The tool was used to assess patients before and after programmes of therapy so that improvements could be evidenced.
- We saw details of an audit that had been carried out at Haywood Community Hospital to compare results of musculoskeletal conditions diagnosed by physiotherapists against results of MRI scans. Eighty-five percent of the diagnoses were the same, which demonstrated that physiotherapists were providing effective assessments of patients' conditions. Where diagnoses were different this was fed back to individual staff or the team, as appropriate, to improve practice.
- Therapists in the South division told us that they asked patients at the start and end of their treatment about the difficulties they experienced, such as pain and reduced movement at these times. We asked the trust to provide us with information about patient outcome scores. The trust told us that this information was recorded in the patient's records and was not currently reported centrally.
- We found that 73% (38) of patients did not return to their doctor for the same problem following receiving

treatment from the East Staffordshire community physiotherapy service. In the survey 93% of patients said that they had found the advice/treatment either very helpful or helpful.

- The trust had taken part in the National Audit of Intermediate Care service user questionnaire for home based and enablement service. The local interim report showed positive patient outcome improvements but there was no comparison with other similar services. Thirty-six per cent of patients reported improvements in mobility, 44% reported improvements in the category of personal care and 41% reported improvements in food preparation.
- Community nurses at Moorlands Medical Centre told us they did not have time to complete any clinical or patient outcome audits due to their workload of home visits.

Competent staff

- Senior managers told us that all clinical staff should have clinical supervision shifts, where their practise was observed and assessed by a senior clinician. Therapy staff told us they received regular clinical supervision however community nursing staff at all the locations we visited told us that it happened very rarely, if at all. Clinical supervision is a requirement for continued registration by all clinicians to maintain safe and effective practice.
- At Kidsgrove Medical Centre, one community staff nurse told us they had not had any clinical supervision since starting working for the trust over six months earlier. Another community nurse told us they had not had any formal clinical supervision for several years. Clinical supervision was sometimes cancelled due to workload capacity.
- At Hanley Health Centre, staff told us they did not have formal clinical supervision however, informal discussions about individual cases and best practice took place between staff, community sisters and matrons and the clinical team educator was often seen visiting the team.
- Data provided prior to our inspection showed that 59% of community staff had completed an appraisal which was well below the trust target on 90%. During our inspection, we saw there was considerable variation

Are services effective?

across teams. Some had a 100% appraisal completion rate, others were much lower. For example, East Staffordshire (Inner) community nurses had a completion rate of only 14%.

- Non-compliance with appraisals and training was listed as an 'amber' (high) risk on the North community's risk register.
- Therapy staff at all the locations we visited told us they had regular annual appraisals and six-monthly reviews.
- Competency assessment frameworks to test clinical competency in specific areas were in place. Competencies should be reviewed on a regular basis but staff told us this was not happening due to pressure of work.
- Senior managers told us that new staff were not considered to be part of the operational team until they had completed all their competencies, however at all the locations we visited we were told there were community nurses working independently who still had some competencies to be signed off. These nurses would only carry out procedures for which they had been assessed as competent.
- Staff told us that the trust provided them with training to support and enhance competencies in particular skill areas relevant to the service. Some staff told us they had additional training in infection prevention or leg ulcer management and they shared this learning with their team.
- There was inconsistency in how much funding and protected time was provided for staff to access courses. Some staff told us it was a balance between meeting the demands of the service and current capacity. Not all requests had been granted, particularly when services experienced long-term absences due to maternity leave, sickness and vacancies.
- Community nurses at Moorlands Medical Centre told us their clinical practice education nurse would regularly tell them about courses they should attend but due to their workload and staffing levels, they were not able to be released from duty to undertake training. Staff at Leek Moorlands Community Hospital told us that their training was regularly postponed due to staff shortages; staff told us they had little or no development.
- Some staff raised concerns with us that they were being expected to take on more acute nursing tasks such as care and removal of chest drains without the training or resources to manage them safely.
- None of the nurses we spoke with had received any guidance or support from the trust on the forthcoming programme of nurse qualification revalidation. We were not reassured that the trust was sighted on the importance of this event and the risks posed by nurses not completing the process.
- There was a robust competency assessment process including self-reflection and supervision for therapy staff.
- Physiotherapy staff at Haywood Community Hospital told us they were provided with frequent in-house training to support their role. They also told us that external training courses were made available but that the in-house courses were often better. We were given details of the in-house training courses, which included sessions on new treatments, case studies, illnesses related to rheumatology and demonstrations of new and existing equipment.
- Therapy staff said that they were appropriately supported to undertake further training and development. Therapists within Uttoxeter teams told us that they had additional training in the review and assessment of shoulders.
- Therapists told us they had regular supervision to review their practice with more senior staff. With the exception of staff at Rising Brook, staff told us that there were no formal arrangements for clinical supervision for community nurses.
- At Hanley Medical Centre, we were shown completed clinical supervision, appraisal and performance review documents for band six occupational therapists. These included development and improvement targets and were well structured. Staff told us they found these processes worthwhile.
- At Kidsgrove Health Centre, podiatry staff told us they had regular protected time for continuing professional development training and were able to give specific examples.
- A community dietician and speech and language therapist told us they also received supervision and had

Are services effective?

one to one meetings with the lead dietician or speech and language therapist. They told us they were able to contact their professional lead for advice and had lots of opportunities for continuing professional development which enabled them to keep up to date with practice.

- A healthcare administrator at Kidsgrove Health Centre told us the trust had supported them through a 20-month advanced apprenticeship in business administration.

Multi-disciplinary working and coordinated care pathways

- There was good collaborative working across all community services. We saw referrals and communication networks between community nurses, social care and home service.
- There was excellent multidisciplinary work within the integrated physiotherapy, orthopaedics and pain service (IPOP's) and musculoskeletal integrated clinical assessment (MCAS) treatment service where individuals worked together to achieve the best patient outcomes.
- The Community Nursing teams in the trust were mostly attached to specific GP practices to facilitate multidisciplinary team (MDT) working. Most community nurses spoke positively about working closely with GPs. One community nurse in Uttoxeter (Northgate) said they had mutual respect and worked well to ensure the patient had the care and treatment they needed.
- Several of the community nursing teams were combined health and social care teams, which included social workers, physiotherapists and occupational therapists. Community staff said although some teams were not fully integrated they felt that improved working relationships between health and social care had benefitted patients.
- There was a 'virtual ward' of frail community patients in East Staffordshire who had complex health problems. There was a 'virtual ward round' every two weeks to discuss patients who were unwell and had frequent hospital admissions. The patient's treatment plan was reviewed by a consultant in older persons' medicine at a local trust to ensure when possible they avoided admission to hospital.
- East Staffordshire community matrons attended monthly multidisciplinary meetings with the local

ambulance service (alongside alcohol liaison and mental health services). The meetings discussed patients who frequently called ambulances or who were frequent attenders at the accident and emergency department. The meeting discussed what assistance patients needed to manage their health more effectively in their own homes.

Referral, transfer, discharge and transition

- Referrals to community health services came from a variety of services including GPs, practice nurses, community nurses, patients being discharged from hospital wards and complex cases in nursing homes and residential care.
- Community nurses in East Staffordshire told us they regularly reviewed their caseload to ensure that they continued to be the most appropriate service to provide care, or if patients could be discharged or referred to other services such as wound care clinics.
- Community therapy staff at Hanley Medical Centre told us they experienced delays in discharging patients because of the availability of social care. They also told us that difficulties were caused by large numbers of patients being discharged from hospitals within short periods of time, such as when the hospitals were under pressure to clear beds. These discharges sometimes happened outside normal timescales and community staff had to work late to ensure that the patients were safe.
- Community nurses were able to arrange direct admission to the frail elderly care unit at University Hospital North Midlands where appropriate and depending on bed availability. This meant that patients who fitted the admission criteria would not have to go through the hospital's emergency department.
- Podiatry staff were able to refer patients direct for orthopaedic footwear without going through the patients' GPs.
- The service at Sandy Lane received about 40 referrals each week but was not able to demonstrate how many discharges they performed each week. We were told by local managers they did not keep records of this information

We saw evidence of several referrals to the continence team that were incomplete, illegible or had incorrect

Are services effective?

details from community nurses. An assistant in the continence team explained how she had to contact the community nurse completing the referral to clarify information. She thought these errors were due to lack of time.

- We saw that once referrals had been submitted to physiotherapy, continence, tissue viability, occupational therapy and pain management services all had initial contact with patients within their targets.

Access to information

- We reviewed information on the trust intranet that staff used to support their work and saw the information was clear and accessible. This also enabled staff to access information about evidence based patient care and treatment through external internet sites.
- Community managers told us that the current electronic systems were not fit for purpose and duplicated staff activity. There were long term plans to change the computer systems and additional administration staff were available in some teams to support community nurses with the completion of information.
- Community staff told us that information was shared during handovers and in team meetings, although team meetings were inconsistent across community nursing
- In community locations, information displayed in staff areas was up to date and relevant. Themes were used to draw attention to particular issues relevant to staff. Staff briefings included information about other services within the trust and other organisations nationally.
- At Audley Health Centre, staff told us that another local community team, Potshill, had recently been disbanded and their workload had been distributed between two other teams. This had caused problems because the Potshill team had been using electronic records and the Audley team were not fully live on that system. This meant that one member of staff at Audley was working solely to merge and duplicate details of the two groups of patients so that none were missed.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw patients' verbal consent was obtained before care was delivered and this was recorded. However, records did not always contain signatures to confirm

that consent to care or treatment had been obtained. Staff told us that tick-box documents which included consent had been withdrawn and had been told it was the responsibility of each nurse to document that consent was given. Nurses told us that because of pressure of work, this is not always completed. Although in 24 sets of patient records we looked at in the North division, we saw consistent recording of consent in all of them.

- We were given a copy of the 'audit of the patient consent process in community services' for the North community adults' division. The audit used data from February 2015 and looked at 45 sets of patient records. Evidence of verbal or written consent was found in 98% of the records, which is below the trust's target of 100%. In the record that did not comply, the audit reported that "There was reason to suspect the service user lacked capacity to make decisions about their treatment" and "It was not known if a mental capacity checklist was used or power of attorney/advance decision existed."
- There were mixed views amongst the community nurses we spoke with regards to carrying out the mental capacity assessment of a patient. Some staff were clear on their understanding and their responsibilities, other less so. Some staff told us that if a patient refused treatment but they thought there was doubt about their capacity to do so they would contact the patient's GP and ask them to carry out an assessment. The nurse would then return at another time after the assessment had been done.
- Mental capacity assessments are only valid at the time they are completed, at the point of care, and cannot be carried out in advance as mental capacity can change quickly due to existing medical conditions. Nurses working in the community should be aware of the content of the Mental Capacity Act 2005 and should be trained to carry out capacity assessments to allow them to work in the best interest of their patients.
- At the time of the inspection, the trust did not have a policy on the Mental Capacity Act. We were told as an interim measure, staff were provided with information through internal communications.
- The trust told us that training on the Mental Capacity Act 2005 was mandatory, every three years, for all front line

Are services effective?

staff with a care management responsibility. There were 1,290 clinical and medical staff trained in the Mental Capacity Act 2005, equating to less than one-third of all staff. Data for adult community services alone was not available.

Are services caring?

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

Summary

We have rated this service as good for caring: This is because:

- People were supported and treated with dignity and respect and they were involved as partners in their care.
- Feedback from people using services was positive about the way they had been treated by staff.
- We observed many interactions between patients and staff and they were consistently respectful and kind. Therapy and nursing staff clearly cared for their patients and their relatives.
- Staff responded compassionately to patients' concerns and took time to reassure and support them.

Compassionate care

- Care and treatment of patients across all services was empathetic and compassionate. Staff promoted and maintained the dignity of all patients when they delivered care from various community settings such as community clinics and in patient's own homes.
- We accompanied community staff on over 30 home visits to patients. In every case, we saw compassionate, kind care being provided and patients being treated with dignity and respect.
- We also saw caring, compassionate interactions between therapy staff and patients in every clinic location where we observed that service.
- Feedback from people who used the service and those who were close to them was positive about the way staff treated them.
- One patient said: "(Community nursing) staff are caring, we have no concerns, we've received everything we need and we are happy with our care".
- Where we saw that staff were busy, this was not apparent to patients. One patient commented: "They were never made to feel their appointment was rushed". We observed another patient become distressed when they told the therapist about the amount of pain they

experienced. The therapist did not rush the patient, gave them tissues, and only proceeded with the consultation when the patient was comfortable and composed.

- Patients told us they received excellent care particularly from the occupational therapists and community nurse services. We heard comments such as "the physio team here are brilliant, I've seen such an improvement in my condition, they always listen to me and answer any questions I have" and "all the staff are very polite and caring".
- A podiatry patient at Kidsgrove Health Centre told us they were always treated with dignity and respect, that the clinic staff and podiatrists were always very professional and that they had always been satisfied with the level of service they had received.
- At Leek Community Hospital, one patient who had been attending weekly appointments with a community nurse for the preceding two months told us that the staff had made it a "really positive experience".
- The trust used the Family and Friends Test as a means of receiving patient and family feedback. The trust target for people who recommended the service was 90%. Information we saw for patients surveys returned between April and September 2015 showed that the trust target was met. The trust achieved an overall score of 97% of people who would recommend the organisation to friends and family.

Understanding and involvement of patients and those close to them

- We saw staff taking time to listen to patients' concerns and explaining care plans in clear, simple language to make sure patients understood what was going to happen. We also saw staff explaining treatment and therapy plans to patients and talking to them about things they were doing in their homes to improve their safety and quality of life.

Are services caring?

- Staff asked people if they had any questions, and treatment plans were summarised to ensure the patient understood. Where appropriate, people were asked about their personal goals and what they would like to achieve.
- We spoke with seven patients at Hanley Health Centre, who all told us that staff took the time to explain details of their care and always had time to answer questions. Four patients we spoke with at Haywood Community Hospital told us they felt fully involved in decisions about their care.
- People were involved and encouraged to be partners in their care and in making decisions, with support they needed. Plans of care centred on what the patient wanted. One person and their husband told us, “all the nurses have been brilliant and they all explain things”.

Emotional support

- Staff helped patients and those close to them to cope emotionally with their care and treatment. They were enabled to manage their own health and care when they can, and to maintain independence.
- We observed community nursing staff giving holistic care including support for close relatives. Where appropriate, patients and their carers were given details for support groups.
- All staff we spoke with told us that part of their job was to provide emotional support not just to patients but also their carers and families. During home visits, staff demonstrated knowledge of people and their unique situations and provided tailored emotional support.

Are services responsive to people's needs?

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

Summary

We have rated this service as requires improvement for responsive: This is because:

- Although targets had been set for responding to urgent and routine appointments, the service did not routinely collect data on performance against these targets.
- Volume of work reduced the ability of staff to respond to patients' needs. Some patient contacts were not made and passed to the night team who were also unable to see the patient. Appointments were moved or cancelled frequently and at short notice as resources were unable to cope with demand.
- Facilities for people with a disability or mobility issues from their clinical condition needed improving in a number of areas.

However, we also saw that:

- The trust saw patients quickly if they needed an urgent referral.
- The trust operated a 'virtual ward' system to support people in the community rather than admitting to hospital.

Planning and delivering services which meet people's needs

- The trust held four main health and social care contracts and a range of smaller/single service contracts. These were two health contracts (one North and one south), specialised commissioning and a Staffordshire County Council contract for adult social care.
- The trust and staff in clinical teams were aware of people's complex health needs and services were well coordinated to meet those needs.
- Adult community services planned and coordinated care packages for patients who needed integrated teams to provide support at home. For example, we saw patients being supported by the community nurse, occupational therapists and social services.

- Staff told us that as an integrated health and social care team the service facilitated setting up short and long-term care packages and reduced delays in the transfer of care.
- We observed that a lifestyle management support service had been set up for patients with weight management, smoking cessation or alcohol management needs. Supporting these needs may help reduce other health conditions.
- Within East Staffordshire, the trust had a community "Virtual Ward". The ward was made up of patients who had several and/or complex health problems. The key aim of the virtual ward was to care for acutely ill patients within the community and, when possible, prevent avoidable hospital admissions.

Equality and diversity

- Staff confirmed translation services were available for people whose first language was not English and were able to provide examples where the interpreter service had been used. One staff member told us they were able to access interpreters if needed, but would use family members sometimes if they were there but told us it was not normally acceptable.
- In the South division, we saw limited advertisement of the interpreting service to improve communication with ethnic groups. One notice we saw detailing interpreting services was at the top of a notice board in very small text. Staff told us they would arrange interpreting services if required.
- A dietitian in East Staffordshire told us they had a large number of Urdu and Punjabi-speaking patients. They told us they were able to get diet sheets in different languages if needed.

Meeting the needs of people in vulnerable circumstances

- Staff in adult community services were focused on meeting the needs of patients and individualised care plans reflected this.

Are services responsive to people's needs?

- We saw good evidence of patients being offered choices about care and treatment and staff actively sought best options to work around patients' daily lives while balancing safe methods for best health outcomes.
- We observed community staff providing care and treatment for people living with a learning disability. We saw that staff explained the exercises they needed to do and the treatment they would give in a way people could understand.
- Staff explained two members of staff attended visits with some patients, depending on the assessment of their need, e.g. patients living with a learning disability or with complex needs, such as patients living with dementia.
- The colour scheme in the outpatients department at Leek Moorlands Community Hospital had strong contrasts between areas such as walls, handrails and doorframes. This meant that the needs of people living with impaired vision and those living with dementia had been considered.
- However, the colour scheme in the outpatients department at Haywood Community Hospital was not designed with the needs of patients living with impaired vision or dementia in mind. Handrails and walls were the same, pale grey colour and handrails did not stand out visually.
- The waiting area at Kidsgrove Health Centre, which was used for community clinics, had an induction loop to provide enhanced audio for patients and relatives who used hearing aids.
- A patient living with impaired vision told us that the signage at Leek Community Hospital was not designed with visual impairment in mind. We saw that the colours of the signs did not provide good contrast between background and lettering.
- The disabled toilet at Kidsgrove Health Centre only allowed transfer from one side. This may have caused difficulty for some patients depending on their individual needs.
- The falls therapy team at Cheadle Community Hospital maintained a contact list of local voluntary car scheme drivers to minimise the cost of transport for patients who did not have access to their own vehicle or any other mean of transport.

Access to the right care at the right time

- The community nursing services provided care seven days per week. Some teams provided the service 24/7 whilst others worked days and evenings with cover overnight provided by community intervention teams. Patients in the different areas all told us that they knew how to contact a nurse at night if required.
- Community services were provided in people's home as needed and clinics and groups were established in community locations. Occupational therapists undertook home visits with physiotherapists and staff from the social care team to ensure holistic care was provided.
- Community nursing staff told us that all urgent patient referrals would be visited within two hours of the referral and non-urgent visits would be visited within two days. Community nurses (in all areas we visited) told us that end of life and pain relief visits would always be prioritised. We saw when we visited Rising Brook, Balance Street and Bradwell out-of-hours teams that staff went out immediately in response to requests for visit for people requiring treatment for pain relief and vomiting.
- Therapy staff told us that referrals identified as urgent would be seen within 10 working days and routine or non-urgent referrals would be seen within six to eight weeks.
- We asked the trust for information about response rates for 'urgent and non-urgent' visits. The trust was not able to provide us with information about how long patients waited. The trust told us that as they were not contracted to provide 'urgent' and non-urgent services, this information was not collected and only available on an informal basis. From data collected locally, we saw that the majority of patients for all therapies were seen within two weeks of their referrals but that patients waited up to twice this length of time in the South division for physiotherapy, occupational therapy, speech and language therapy, and podiatry.
- Staff told us they were not always able to undertake all visits. They told us that visits would be assessed and low priority visits such as continence and skin assessment

Are services responsive to people's needs?

were sometimes postponed or cancelled. We asked the trust for information about the numbers of visits that were postponed but they were unable to provide us with this information.

- Nurses working at several locations in the north community teams told us they had raised concerns about the number of calls being missed by day staff due to the volume of work and large geographical area they covered. They also told us that missed daytime calls that were passed to the out of hours team often came back to them the following day because the out of hours team had not been able to attend them. The trust did not routinely record this information so we were unable to determine how frequently this occurred.
- One patient told us they did not always know if the community nurse was visiting in the morning or afternoon which made it difficult for them to plan other activities. Some patients had their visits cancelled at the last minute and rescheduled because the 'nurse was very busy'.
- Assessment to refer to the continence service was aimed to be achieved within three weeks; we saw delays of up to six months due to community nursing capacity. We saw this was a problem during our 2014 inspection visit and that it remained unresolved.
- Some areas such as Stafford used a single telephone access point to contact community nursing services between 8am and 5pm. After 5pm requests for community nursing could be made via locally identified numbers for the out of hours team. Access in East Staffordshire was via local telephone numbers where patients or other referrers could leave a message on an answerphone asking community nurses to visit.
- We observed in patients' records there were contact numbers for the community nursing service including the out of hours service. However, we found that one of the two identified telephone numbers for the out of hours service in East Staffordshire in patients records was not correct. Out of hours staff we spoke with agreed this number was no longer in use. This meant that patients may not be able to contact community nurses should they need to.

- Physiotherapy patients at Haywood Community Hospital told us that their appointments always ran on time and that they did not have to wait long for appointments after being referred by their GP.
- Podiatry staff at Kids Grove told us patients requiring an urgent appointment would be seen within 48 hours, 10 days for patients considered as having intermediate needs and 30 days for routine cases. Patients told us that emergency appointments were available if needed, sometimes same day but at most within three days. Due to staff sickness, the team prioritised patients who had urgent and intermediate needs and, as a result, routine appointments were two weeks behind target at the time of our inspection.
- Therapy staff at Leek Moorlands Community Hospital told us they had a target waiting list time of four weeks, but were running at five weeks at the time of our inspection.
- We were given details of referral to treatment times for occupational therapy, physiotherapy, podiatry and speech and language therapy. In the North division, 97% of patients waited less than four weeks for their first appointment.
- The diabetic team had set up an evening clinic every two weeks to accommodate patients that worked during the day. Staff reported it was well used and patients liked having the option of late appointments.

Learning from complaints and concerns

- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally and how to escalate when required. Staff we spoke with were aware of the complaints procedure and told us where possible they would try to resolve patients' concerns themselves.
- Lessons learned from complaints were communicated to staff through various formats such as team meetings or via email.
- We saw examples of action plans that had been agreed to improve individual staff members' practice following clinical concerns.
- There were 85 formal complaints about adult community services in the previous 12 months. Sixteen of these were upheld.

Are services responsive to people's needs?

- There was inconsistency in the way that community teams maintained a local register of complaints, and

how they informed patients about raising concerns and complaints or who to contact. Some teams provided leaflets; some had posters up and other teams provided information on request only.

Are services well-led?

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

Summary

We have rated this service as inadequate for well-led: This is because:

- Staff did not feel supported by senior managers and felt they did not understand the daily challenges staff faced.
- Staff were under significant workload pressure. We did not see an effective response to this from the senior management or the trust executive.
- Community nursing teams demonstrated a strong patient focus but many staff described to us a culture of fear and anxiety about the safety of the service.
- The delivery of high-quality care was not assured by the leadership, governance and culture of the service. We found there were inconsistencies with effective leadership across adult community services.
- Although staff were clear on the purpose and vision for the service, the values were not widely shared and there was no clear strategy. Many staff expressed to us their concerns about the future of service delivery.

Service vision and strategy

- The trust's vision was, "To deliver personalised care of the highest quality with the best possible outcomes for users and carers empowering them to be independent". We found that the majority of staff shared this vision and understood how it related to their service.
- The trust's values were 'quality, people and responsibility'. We asked staff in all the locations we visited what they understood about the values and what they meant to them in their provision of patient care. None of the staff we spoke with had heard of the values. When we asked one team of seven community nurses about the trust's values they told us they were simply too busy doing their jobs to look at them and had no idea what they were.
- Staff in many areas were unsure of the future of the service due to many reconfigurations and redesigns and wanted to be more involved in shaping and influencing the future of care. Staff told us they were faced with

constant change. They perceived these changes were frequently not thought through or well informed. This had led to inconsistency with the way that care was delivered in neighbouring areas.

Governance, risk management and quality measurement

- The trust had an identified governance structure in place.
- Community nursing teams should have regular monthly team meetings where key quality and safety issues were shared and discussed. In addition to team meetings, each division held monthly business meetings. These meetings were responsible for implementing the trusts quality framework as well as monitoring business performance. The Professional Leadership group worked to ensure that best practice and patient safety was maintained through collaborative working across all the key clinical groups.
- The trust confirmed that area managers attended the professional leadership meetings and the divisional business meetings.
- Staff confirmed that team meetings took place in some areas and we saw minutes that confirmed this. However, we noted that in a number of places team meetings did not take place. One team had not had a team meeting since July 2015. Staff told us that information was not always shared, such as learning from incidents or complaints.
- Local managers were aware of the challenges around staffing and meeting caseload demands. Staff had raised issues with managers and completed incident forms. However, problems persisted and this was having a significant impact on staff and patients. Staff told us they understood the system for reporting workload issues, and had done so, but workload pressures meant they no longer had time to report each individual patient that was cancelled or postponed due to workload as an incident.

Are services well-led?

- The workforce planning tool exercise had not been repeated despite acknowledgement that activity levels and staffing structures had changed since it was originally completed. Many staff we met frequently worked additional unpaid hours to meet the needs of patients; this was not being acknowledged or addressed by managers.
- Many teams were providing services with below establishment staffing levels and this was having an impact on patient care. For example, the night service for East Staffordshire did not provide a qualified nurse on 10% of all shifts for five months in 2015. Managers were aware but did not take steps to ensure a qualified nurse was on duty.
- Nursing staff told us and we observed that visits to patients are cancelled or passed from one shift to another. The service had no mechanism in place for monitoring the frequency of the cancellations and to ensure that this is not repeated. There were targets set for responding to urgent and routine appointment but the service did not routinely collect data on performance against these targets.
- We saw little action to mitigate the impact of this by local and divisional management teams. Our observations during the inspection, and our analysis of the data from previous shifts did not show any significant management action to cover shifts that ran without a qualified member of staff.
- Adult community services in each division maintained a risk register that then fed into the divisional risk register and then in turn, the corporate register so that the board had oversight of the main areas of risk for the service.
- There were two risk registers for adult community services. There were 27 risks on the South division risk register. The majority of risks (16) identified were staffing and difficulties due to vacancies and patient need and the potential impact on patients. There was no specific risk identified about the lack of arrangements to ensure that a qualified nurse was on duty overnight in East Staffordshire.
- The North division community's risk register had 38 entries, Six 'red' (very high) risks, such as the risk of delays to service provision and of not meeting cost-saving targets. Staffing levels risks were rated as 'amber' (high).
- A risk about access to the pharmacy department at Haywood Community Hospital had been on the trust's risk register since April 2015. We were given electronic copies of the divisional risk register for the north community and the medicines risk register, however this risk was not listed on either. Pharmacy staff told us that no action had been taken to mitigate this risk and that the trust's senior management team did not appear to be sighted on local risks.
- Staff and managers conducted regular documentation audits to analyse the quality of recorded information in community services. However, only the quality of the written evidence was audited e.g. date, time, legibility and signature of each clinical entry.
- Risk assessments and content of notes were not audited. We saw from our inspection that risk assessments had not been reviewed in a timely manner, one since 2013 and the quality was variable.
- Adult community services had processes in place for carrying out clinical audits. It took part in the monthly safety thermometer campaign to measure and reduce harm to patients at risk of falls, pressure ulcers and catheter-acquired urinary tract infections.
- Specialist services such as physiotherapy and diabetes were conducting audits to improve and progress patient treatment. Staff did not report the findings of the audits to senior management to facilitate change.

Leadership of this service

- Community nursing staff told us that they were well supported by their band 6 and band 7 supervisors and team leaders, and that communication by email was effective and kept them informed. They told us that minutes of team meetings were also circulated by email so that team members who were not able to attend meetings were aware of what had been discussed.
- Although most staff told us their immediate line managers were visible, accessible and approachable, some teams in the North division told us that they rarely saw their team leaders as they were based in offices

Are services well-led?

separate from the nurses' bases. On the days we inspected a team leader was present at two of the bases. Staff told us the team leader had not visited for weeks prior to our visit and they believed they were only there because of the inspection.

- Staff at Hanley Medical Centre told us that funding was available for them to complete the NHS Leadership Academy 'Mary Seacole' postgraduate certificate programme however, they had problems completing applications for the course as there were no managers on site to countersign them.
- Physiotherapy staff at Audley Health Centre told us they felt well supported by their line manager who kept them informed, provided feedback on their performance and held team meetings every two months. However, they also told us they felt no connection to the trust's senior management and had only met the manager above their own line manager twice in over five years.
- Physiotherapists and occupational therapists, a dietician and speech and language therapist told us they had excellent managers who were supportive.
- The heart failure team felt isolated, they had not had a line manager since the post had been vacated and we were told there was no plan to recruit to the vacant post. They felt they were not listened to.
- Nursing staff at several locations told us that the merger of health and social care was problematic because teams only had one manager each, and if that manager was from a social work background, they were not familiar with the working patterns and methods of community nursing teams.
- Staff told us they felt senior trust managers did not listen to them and were out of touch with their daily challenges. Some areas reported seeing the chief executive and senior managers. Community nursing staff told us they had not seen the Director of Nursing and were not sure who they were.
- During individual staff interviews and focus groups we heard many stories from nurses we spoke to about the impact of low staffing levels and high demand on them personally and professionally. We consistently heard that community nursing staff felt despondent, demoralised, frustrated and let down by senior managers. Staff spoke about a "culture of fear" around patient harm incidents, and told us they were scared of being blamed for things beyond their control.
- Nursing and therapy staff in all of the locations we visited told us that they never had proper meal breaks and rarely finished work on time due to their workload. Late finishes were recorded for time off in lieu (TOIL) but due to staff shortages, they were rarely able to take the time back. Many staff told us they no longer bothered to record TOIL as they were unable to take the time off.
- Most of the community nurses we spoke with told us that they worked on their laptops at home after their shift had finished, as they did not have time to complete their administration during working hours.
- Staff working for the night service in East Staffordshire told us their concerns about the service had not been listened to and had been dismissed by managers. One nurse reported concerns over staffing levels to management that were then escalated. A member of senior management attended the team and appeared more interested in identifying who had made the comments than in resolving the issue.
- Some staff reported positive job satisfaction; we found this particularly in specialist services.
- The results of the 2014 NHS Staff Survey revealed that the trust performed worse than the national average for several areas including, job satisfaction, stress at work, motivation and structured appraisals. The trust performed better than the national average for support from immediate managers, pressure to attend work when unwell, and experiencing physical violence or harm from patients, relatives and staff.

Culture within this service

- We found staff were hard working, caring and committed to the care and treatment they provided. They demonstrated a strong patient focused culture. Staff across all adult community services were dedicated and compassionate and wanted to provide the best possible care for their patients.

Public engagement

- At locations with public access we saw business cards on display, which read "We would love to hear your feedback" and invited patients and relatives to complete the trust's online survey. The internet address for the survey was also provided.

Are services well-led?

- Community teams in the North division had a ‘user and carer experience survey’. The survey was anonymous, and included a range of questions about the level of care patients received during their appointments. Other services used comment cards to capture feedback from patients. The notice board in community locations displayed thank you cards demonstrating that patients and relatives had taken the time to write and thank staff.
- Patients could access information about services on the trust website, the locations they were provided from and contact details where they could find further information.
- The community nursing team in Uttoxeter told us they had recently had a stall at a local ‘over 50s forum’ where they told people about community nursing services and how services could be accessed.
- An online survey had been conducted to assess how effective community service for adults’ staff felt communication was with senior managers. The results showed that only 28% of the trust’s staff (who responded) felt that communication between them and senior managers was good.
- Due to the number and scale of changes the trust had undergone, they had developed a support role of ambassador for cultural change. We were told at one location we visited the ambassador had attended the location due to concerns raised regarding workload and staffing numbers a few months prior to our inspection. She compiled a report and then submitted it to the chief executive. Staff said they had not heard any feedback regarding actions since.

Staff engagement

- The trust used a combination of email, intranet messages and newsletters to engage with community staff. We saw information on the trust web site informing staff about the CQC inspection.
- Staff in all the locations we visited were aware of the trust’s weekly newsletter, ‘The Word’, and told us they found it useful and informative.
- The trust held regular “one vision” staff engagement events where staff could speak with senior managers. We found that while many staff were aware of these events, not all were. Staff who were aware and had attended spoke positively about the events, but many staff told us they would like to attend but could not be released to go to them due to their workload.
- The area manager for long-term conditions, out-of-hours and supportive services in Stoke held monthly meetings for band 8a, band seven and band six nurses. We were given copies of the minutes from a selection of these meetings, which showed discussions about staffing, incidents, Nursing and Midwifery Council revalidation, new treatments and care procedures, complaints, appraisals and plans and developments for the trust.
- One band 6 community nurse in the north division told us that they were aware of the weekly band six meetings but were never able to attend due to their workload.
- We were told by managers and staff that monthly meetings between adult community services took place to promote effective two-way communication of information across the trust. Staff told us it was not always possible to attend meetings due to workload. Some staff felt unable to discuss issues because of a lack of opportunity and their issues went unheard.
- During our inspection, several staff showed us an email they had had from the trust’s management, which was entitled “Example CQC inspector questions”. The attached document listed 26 questions that the trust expected would be asked during our inspection, and for each question gave suggestions for things to think about when responding.

Innovation, improvement and sustainability

- We found that community services were inequitable between the North and South divisions demonstrated by staff availability (around out of hours arrangements) and waiting times for therapy services.
- Managers told us that they had a cost improvement plan for their service. However, several managers told us following changes to teams such change of location or changes to avoid patient hospital admissions (Community Intervention teams) these plans were no longer relevant and were unrealistic. Managers told us they had highlighted this to senior managers and were awaiting confirmation this had been changed.

Are services well-led?

- We were not confident that innovation and improvement were actively encouraged and supported by managers. Staff we spoke with were unable to give us examples of how good practice in one area had been shared and implemented by another team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 (1) (2) (a) (b) (c):</p> <p>(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.</p> <p>(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to —</p> <p>(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);</p> <p>(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;</p> <p>(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;</p> <p>There were no systems and processes in place to review and monitor the quality and effectiveness of patient care. There was no oversight of the planning and delivery of patient visits and systems for handover were not robust.</p> <p>Governance arrangements were in place but were inconsistent and not well managed across the organisation. Managers were not taking action to mitigate significant issues that threaten the delivery of safe and effective care in community services for adults.</p>

This section is primarily information for the provider

Requirement notices

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1) (2) (a) (b) (c):

18—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

(2) Persons employed by the service provider in the provision of a regulated activity must —

(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and

(c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

The system for assessing staffing levels was ineffective, there were substantial staff shortages affecting the ability to provide care. Demand for community nursing visits routinely outstripped capacity, with visits regularly postponed or cancelled. Staff routinely worked extra hours to meet patient needs.

Patients who call the district nursing evening or overnight services were being put at risk as the trust had not made sufficient arrangements to ensure there were registered nursing staff available on all shifts. Escalation plans were unclear and inconsistent.