Leicestershire Partnership NHS Trust

RT5

Community health services for adults

Quality Report

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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)
RT5YC	Ashby and District Community Hospital	Ashby and District Community Hospital	LE65 1DG
RT5YD	Coalville Community Hospital	Coalville Community Hospital	L67 4DE
RT5YF	Hinckley and Bosworth Community Hospital	Hinckley and Bosworth Community Hospital	LE10 3DA
RT5YG	Loughborough Hospital	Loughborough Hospital	LE11 5JY
RT596	Melton Mowbray Hospital	Melton Mowbray Hospital	LE13 1SJ

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good

We rated Community health services for adults as good because:

- The community healthcare services provided by Leicestershire Partnership NHS Trust were judged to be good. We did not identify any significant community wide areas for improvement but did find many exemplary services provided by the trust. These included the Older People's Unit at Loughborough Hospital, the Hand Injury Service, the splitting of planned and unscheduled community nursing services with a single point of access, podiatry and the specialist management of long term conditions.
- Patient outcomes for people using trust services were very good and the trust was able to demonstrate that their services had a positive impact through good data collection and review mechanisms.
- The trust had a culture of promoting staff learning and development and encouraged staff to share best practice and innovation. Staff told us the trust was a good place to work.

Summary of findings

Background to the service

Background to the service

Community Healthcare services were provided by the Leicestershire Partnership NHS Trust to people living in Leicester, Leicestershire and Rutland. The trust provides services from a number of locations across the geographical area and in people's homes.

Community Adult Services in Leicester, Leicestershire and Rutland included:

- Bladder and bowel services
- Community rehabilitation and falls services
- Planned and unscheduled community nursing, including out-of-hours services and clinics
- Tissue viability team
- Podiatry
- Speech and language therapy services
- Musculoskeletal therapy services
- An older persons assessment unit
- Community nurse specialists
- Community dietician team

The trust also provides primary medical services for adult male offenders but the care and treatment provided by trust staff at these two locations was not reviewed as part of this inspection methodology.

Services were provided in patients' homes or from community hospitals in Loughborough, Melton Mowbray, Coalville, Ashby de la Zouch and Hinckley and Bosworth as well as at a variety of health centres and medical centres across Leicester city and the counties of Leicestershire and Rutland.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting

The team that inspected this core service included a CQC manager, two inspectors, two specialist nurses and a general practitioner. The team also included an Expert by Experience; a person who had used services.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 10, 11 and 12 March 2015. During the visit we held two focus groups with a range of staff who worked within the service, such as nurses, health care support workers and students. We talked with about 35 people who use services (including 5 telephone interviews) and four carers. We spoke with six managers, and about 40 qualified and 16 unqualified staff. We observed how people were being cared for in clinics and their own homes and reviewed care or treatment records of people who use services.

We visited community hospitals, reviewed the general and specialist clinics, community nursing and podiatry services. We accompanied specialist nursing staff and community nurses on home visits; we spoke with staff of all grades from all areas of the service individually and in groups.

What people who use the provider say

Every patient, relative and carer that we spoke with was very positive about the service they received. We were told that the staff were, "Amazing and gave 101%." People said the staff made them feel comfortable and at ease and that they had confidence in their professional option.

People made specific comments about individual staff and had clearly developed good relationships with, "their regulars". Others told us about the specific services they used and how well their care and treatment was provided. One person said, "I have been everywhere, private and NHS with my back but the only ones to make a difference are the Loughborough physio team."

Someone using the OPU told us, "You can't fault it. I have been seen by a specialist and a matron already and had loads of tests and I have only been here half an hour. They are lovely and made me and my daughter a nice cup of tea."

Good practice

- The Speech and Language Therapy team (SALT) had initiated a pilot where they worked with the dieticians and staff from local care homes to identify training needs. The team then provided the training for the homes and improve the care patients received. The team had been awarded a Leicestershire Partnership Trust Excellence Award for this project.
- The Trust Heart Failure Team had started an initiative to 'grow their own;' nurse specialists. There were three Band 6 nurses on a three month induction. A competency framework was being put in place to support these nurses in developing the necessary skills.
- An integrated discharge team had been established working with the acute trust. Referrals were triaged to determine the timing of the response. The service was available across the whole trust geographical area.
- The Older People's Unit was an excellent resource providing comprehensive two hour assessments for elderly people and organising support and care services so they could return to their usual place of residence.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure bank staff complete mandatory training in line with trust requirements.
- The trust must ensure teams are adequately staffed to prevent impacts on workloads due to staffing shortages.

Action the provider SHOULD take to improve

- The trust should ensure the backlog of patients awaiting phlebotomists' diabetic reviews in Leicester city is addressed.
- The trust must review the use of agency staff to ensure patients receive care in a consistent and planned manner.

Leicestershire Partnership NHS Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- There was evidence of real learning from concerns and incidents that was disseminated across community healthcare services.
- Infection prevention and control was well understood by all staff we observed and there were adequate resources.
- High levels of mandatory training were completed by all teams.
- There were policies in place to deal with expected risks, such as deep snow or flooding, which were known to all staff.

Incidents, reporting and learning

- One never event had been reported via the Strategic Executive Information System (STEIS) for the period 2013-2014. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In this case a patient was prescribed a daily dose of the drug methotrexate that should be administered weekly.
- We found the trust had investigated the never event, actions regarding medicines management and prescribing had been implemented and learning had been disseminated to staff throughout the directorate.
- The highest incidence of incidents reported by the trust in 2014 via the National Reporting and Learning System (NRLS) was related to 'Community nursing' speciality (70%). However, 97% of incidents reported resulted in low or no harm to the patient. This suggested a positive culture of reporting within community healthcare services.
- The Musculoskeletal (MSK) service reviewed incidents and alerts on a bi-monthly basis at a team leads meeting chaired by the county physiotherapy services manager.
- Serious untoward incidents were disseminated by email to staff from a central team. If the alert was not relevant

the team leader was required to email back to confirm this. If it was relevant, the team leaders disseminated the information to their teams and they were then required to report back on what action they have taken.
- Regular team meetings were held for all staff teams. We saw from minutes and from discussion with staff that these meetings were used to disseminate information and learning where there had been concerns or complaints from within the directorate and from the wider trust services.
- All staff we spoke with were able to recount where they had reported a concern and where they had seen learning from an incident. Various staff talked to us about learning around a missed pressure wound when a patient attended a continence clinic, an incorrectly dressed leg ulcer which deteriorated and which led to special lower limb clinics being introduced and gave other specific examples of learning from incidents.
- Senior staff were automatically notified when an incident was reported that affected their area of responsibility. For example, any incident categorised as a medicines error went directly to the pharmacy manager.
- The safeguarding lead received copies of all incidents related to patient safety and care.

Cleanliness, infection control and hygiene

- All clinic and hospital locations we visited appeared clean; patient areas were well maintained and free from clutter.
- Public and patient lavatories were clean. We saw laminated cleaning schedules displayed on lavatory walls which indicated regular cleaning schedules.
- On the Older Persons Unit (OPU) we observed a member of staff from the company contracted for cleaning services at Loughborough hospital was very thorough in their work. They were wearing personal protective clothing and using the colour coded mops and buckets correctly to reduce the risk of transmission of pathogens. The staff on the unit told us that this member of staff was allocated to the unit so had developed good working relationships and a pride in the cleanliness of the premises.
- Staff across the organisation were observed to follow best practice relating to hand hygiene and to use personal protective equipment (PPE) appropriately. We were told by numerous staff that there were plentiful supplies of PPE at all times.
- A trust wide Sharps Management Audit 2013/2014 showed that community health services performed well overall with half of the 18 key indicators being scored at 100%.
- Urinary Catheter, Catheterisation and Aseptic Non Touch Technique Audit (Infection Prevention and Control) 2013 – 2014 - An audit of the procedures for urinary catheters, urinary catheterisation and aseptic non-touch techniques showed that 82% of indicators were shown as compliant with the trust policy.
- Where non-compliance was identified in the audit this was addressed with clear analysis and explicit recommendations. For example, non-compliance was noted in respect of antibiotic cover when planning a catheter change. The report stated that this could be explained by the fact that in 20 instances antibiotics were not indicated: Prophylactic use of antibiotics upon change or instrumentation of urinary catheters are not indicated (Health Surveillance Centre 2011) in the majority of patients. The recommendation made it clear that it was vital that staff had an awareness of the Antibiotic Guidance for Primary Care (NHS Leicester City, Leicestershire County and Rutland 2013).
- During the period 2013/2014 96% of prescriptions for antibiotics issued by staff indicated an appropriate length of therapy (41% improvement on the previous year).
- Staff were able to demonstrate that the water outlets such as taps and showerheads were run regularly to reduce the risk of legionella infection.

Maintenance of environment and equipment

- The community hospitals that we visited appeared to be in a good state of repair.
- All mobile electrical equipment had a Portable Appliance Test (PAT) sticker showing that it had been tested and found safe by an electrician. The stickers had a date for retesting of May 2015.
- In the community hospitals we visited there were first aid kits that complied with the Health and Safety (First Aid) Regulations 1981. The names of trained first aiders were displayed throughout the hospital.
- Resuscitation equipment in the OPU was readily available and had been checked in accordance with trust resuscitation policy.
- Failings in equipment provision to community services had resulted in a move to a new provider about 18

months ago. There was a clear service level agreement and evidence of oversight by trust managers. Staff at all levels told us there was no problem with the accessibility of equipment.
- The podiatry service used small portable lasers to provide treatment for some patients. We noted that the trust appeared compliant with the Laser radiation: safety advice issued by Public Health England.

Medicines management

- Medicine charts were appropriately completed in all the individual records that we looked at.
- Medicines were stored appropriately in the OPU, with clear audit trails for obtaining, dispensing and disposing of medicines.
- FP10 prescription pads used to prescribe medication for people who were discharged from the OPU were stored securely.
- The audit of Compliance with Controlled Drug Policy and Standard Operating procedures in Community Settings 2014-2015 (report dated February 2015) showed compliance rates of 99% and 98% against critical criteria over a two year period. There was clear evidence of feedback to each team involved about their performance.

Safeguarding

- The trust safeguarding leads attended team meetings to provide advice and updates over and above mandatory training.
- There was a trust run safeguarding helpline available to staff in all areas of the service.
- We were given a very good example of safeguarding a vulnerable adult. A nurse had seen an incident in a care home and reported it the home manager at the time. On return to their base, the nurse had filled out an incident form and checked that the manager had made a referral to the local authority. The nurse's manager was made aware of the incident and double checked that the proper procedures had been followed by the home manager.
- The trust whistleblowing policy was available on the intranet and was known to staff.
- Staff we spoke with said they would feel confident that appropriate action would be taken if they raised concerns with their line manager.

Records systems and management

- Staff completed information governance training annually. The levels of completion within community services ranged from 81% to 97% against a target of 95%.
- The Clinical Record-keeping Audit for Long Term Conditions (CHS) 2013-14 showed that records were very well completed. Of the 37 relevant key indicators, the service scored 100% on 26 of these with the vast majority of other indicators being rated green (on or above target).
- The Clinical Record-keeping Audit (Single Point of Access & Night Nurses) 2013/14, the Clinical Record-keeping Audit (District Nursing) 2013/14 and the Clinical Record keeping Audit – Speech & Language Therapy CHS 2013-14 showed us that the trust was monitoring the quality of record keeping. Generally high performance against key indicators for the audits was demonstrated with many indicators scored at 100%. Where shortfalls were identified these were addressed.
- Staff used the SystmOne electronic recording system to enable other members of the multi-disciplinary team (MDT) to access relevant information regarding treatment.
- Community nursing teams audited five sets of patient records each month within their team.
- 'Toughbooks' taken out by community staff on visits and to clinics where the desktop computers were not available were password protected.

Mandatory training

- The level of mandatory training across the adult community healthcare services was exceptionally high. In podiatry and the Older Persons Unit (OPU), for example, there was 100% completion of all mandatory training for all staff groups.
- Several of the community nursing teams also demonstrated 100% of staff had completed the core mandatory training.
- In community health services for adults there was an overall 95% completion rate for core mandatory training.
- Bank staff completion of mandatory training rates were lower than for permanent staff but were better in community healthcare services than in other specialities. The trust had identified this as a shortfall and taken steps to improve the rates.

Good

Are services safe?

- The trust issued a newsletter to bank staff informing them of changes to the policy that required them to complete mandatory training.
- Bank staff were required to complete mandatory training and had access to the e-learning modules. An action plan dated October 2014 showed that the trust was monitoring compliance with this requirement.

Lone and remote working

- The trust had a lone working policy that was known to all staff that we spoke to about this.
- Staff were provided with mobile telephones and personal alarms.
- One team manager for unscheduled care was able to tell us in detail about the action they would take if a member of staff failed to report into the office at the end of their shift. They were able to show us how they knew where any member of their team was expected to be at any given time.
- Several team leaders told us that they or a manager colleague would always keep their own mobile telephone switched on until all the team had reported in as having finished their shift.
- Most staff had consented to their managers keeping details of their cars, their personal mobile phone numbers and their next of kin for use if their whereabouts had become uncertain.
- One community nursing team were able to show us risk assessments where it was felt that it was unwise to attend a patient in their own home without a second member of staff. One senior manager told us that, "The staff would never knowingly be put at risk," and a second staff member was always authorised if requested.
- We were made aware that one nurse had been in a situation where a relative had become aggressive. The nurse had defused the situation at the time but added a risk alert on the Systm One recording system to inform other staff so that appropriate risk mitigation could be taken before further visits.

Assessing and responding to patient risk

- We observed one nurse who had increased the frequency of home visits to a patients whose leg ulcers were leaking through their bandages and stopping them going out because they were embarrassed by the staining.
- We spoke with partners from a local GP practice who were able to tell us how the Virtual Ward programme worked in practice and had resulted in reduced admissions for many of their frail elderly patients.
- The unscheduled care team could provide an initial assessment via a home visit within two hours of referral.
- The OPU was an exemplar of good practice. The unit at Loughborough hospital was staffed by a consultant geriatrician and an advanced nurse practitioner who provided a holistic two hour assessment of the needs of elderly people referred to the service. They were supported in their role by on site therapists, good links to the local authority and to the unscheduled care teams and the local authority. Unfortunately, the unit was underutilised and many elderly people who could benefit from the service were not referred by their GPs who often admitted people to the community hospitals or the acute hospital rather than to the OPU staff, who could often avoid an admission.
- The heart failure service had a clinical lead who was a consultant cardiologist. They were available for nurse specialists to contact if they had concerns about a particular patient.
- All referrals to the unscheduled care team were triaged by a senior clinician before quickly determining the most appropriate response. We visited one unscheduled care team and observed this in practice.
- We saw the safety thermometer for one team based in Loughborough that showed 100% score for completion of risk assessments for pressure damage, manual handling and malnutrition risk screening,
- We saw that the community services held Pressure Ulcer Ambition Meetings in response to a noted increase in pressure wounds being identified. These were chaired by a Tissue Viability Nurse Specialist who worked with staff from the community teams to identify the cause and find solutions. The trust could demonstrate that 50% of pressure wounds could be attributed to care home practice so looked at ways of improving this.
- The Virtual wards had a night sitter service that employed HCAs within the urgent care team to stay the night with patients assessed as needing constant supervision or care for a short period of time.
- The trust had reduced the number of falls sustained by patients from a peak of 11 in May 2014 to 2 in October 2014.

Staffing levels and caseload

Good

Are services safe?

- Several members of staff from different services within adult community healthcare told us that they were, “Very well resourced, in terms of staffing” and that they had, “Good staffing levels with staff shortages rarely being a problem.”
- Across the trust, community health services for adults had the highest number of shifts filled by bank or agency staff (27%). The risks of high levels of bank staff were mitigated by providing bank staff with mandatory and additional training, shift planning with the team leader and clinical supervision. Many bank staff worked regularly with the same team.
- The trust contracted with a consultant from the call centre industry to review the workload/staffing and systems for the Single Point of Access (SPA) team. The recommendation was to increase the staffing level to 37 from 12 permanent staff with 6 additional staff employed to cope with winter pressures. Funding was agreed with local Clinical Commissioning Groups (CCGs) and the service was on target to be fully staffed by August 2015.
- Several teams that we spoke with were involved in the ‘Fair days’ work’ scheme which had been implemented following large scale transformation of the community services. Minutes of the Shadow Governor’s meeting dated 24 April 2014 corroborated the discussion with staff. The trust had introduced a productivity and workload assessment tool that was benchmarked locally and nationally to ensure clinical credibility.
- Some teams told us their workload was affected by staffing shortages and this was acknowledged by the trust.

Managing anticipated risks

- All staff were aware that they could access volunteers with four wheeled drive cars during periods of heavy snow or flooding. If staff were in reasonable distance they would walk to visits when driving was unsafe.
- The managers of the podiatry service had identified that there was a risk that the podiatry service was not fully compliant with the trust decontamination policy and HTM 01/05 in that only 60% of sites used by podiatry staff had a fully functioning autoclave. This risk was fully assessed and mitigating action taken to reduce the risk. Guidance had been issued that required staff to use disposable instruments for nail surgery and other higher risk procedures. Lower risk procedures such as hard skin removal and nail care were being carried out using equipment that had been decontaminated in a washer/disinfector machine.
- Since a guidance change to the decontamination process a project manager had been tasked with looking at the options to ensure compliance and is developing a hub and spoke approach where instruments are transported to non-compliant sites. This provided us with a clear example of a risk which had been identified and the assurance that the trust staff had responded appropriately.

Major incident awareness and training

- There were policies in place to deal with expected risks, such as deep snow or flooding, which were known to all staff.

Good

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 rated effective as good because:

- The restructuring of community health services and the development of several key initiatives had resulted in a service that was effective. For example, the Older People's Unit was highly effective at reducing the number of admissions to the acute hospital and the Hand Clinic had improved outcomes for patients when compared to GP intervention alone.
- Specialist respiratory and Heart failure services were improving the quality of care people with long term conditions experienced and were widening the service they provided to allow more people to access this.
- Staff were very competent and were provided with good support. Many had postgraduate qualifications in their specialist field and were supported by the trust to deepen and widen their knowledge through sponsorship to degree and masters level courses. There was very much a culture of, "Growing their own" with a cohort of HCAs being about to qualify as Band 4 Assistant practitioners.
- We saw highly effective multi-disciplinary working within the community healthcare services and more widely with colleagues from the acute sector, the local social services department and local GPs. We observed excellent inter professional relationships and communication with clear records of discussions and decisions. Staff within teams worked to support each other and everyone we spoke with or observed ensured that the patients remained the focus of their conversations.
- Consent was seen by all staff as key to good outcomes, with all grades of staff and all professions able to demonstrate a clear understanding of the Mental Capacity Act 2005 and how this impacted on their work. We saw good recording of capacity assessments, discussion with families and best interest decisions. Interpreters were used when necessary to ensure consent was fully informed.

Detailed findings

Evidence based care and treatment

- The majority of serious incidents recorded by the trust (54 of 78) during the period November 2013 – November 2014 were grade 3 pressure ulcers. However on further investigation it was clear that most of these were not attributable to failings in care provided by trust staff. The records that we reviewed and the staff we spoke to provided assurance that the trust had a clear pressure damage prevention strategy that was followed by staff.
- Records that we reviewed and data provided by the trust showed that the service provided care in line with the National Institute for Health and Care Excellence (NICE) Clinical Guidelines 179 Pressure Ulcers: prevention and management of pressure ulcers (2014). We saw that patients had risk assessments and skin assessments that were used to inform care planning and delivery.
- Community nursing teams showed 100% compliance with skin bundle assessment and care plans for the prevention of pressure damage.
- When we observed care being provided to one patient in their home we noted that their pain control was adjusted in line with NICE Clinical Guidelines 140 Opioids in Palliative Care.
- Nurses working in the Doppler clinic followed the guidelines of the University Hospital Leicester vascular department and Leicestershire Partnership NHS Trust. These were available on the SystmOne recording system and referenced 29 evidence based research papers but not NICE Clinical Guidelines. The Band 6 nurse we spoke with was aware of both NICE Clinical Knowledge Summary on the management of uncomplicated leg ulcers 2012 and the Scottish Intercollegiate Guidelines 120 (SIGN) 2014.
- We saw a record that showed a full multidisciplinary discussion about the care of a person who refused assistance with repositioning to avoid pressure damage. An assessment had showed them to have full capacity to make the decision and this was recognised by staff who considered numerous alternative strategies to reduce the risk.
- We saw very good education and support being given to care home staff when a nurse visited to advise on pressure damage to a patient's heels.

Good

Are services effective?

- The trust continence service provided care and treatment in accordance with the NICE Clinical Guidelines 171, Urinary incontinence: The management of urinary incontinence in women (2013). On the initial clinic assessment women were offered a comprehensive assessment that included a physical examination, urinalysis and bladder scan. Referrals were made for specialist medical opinion, whenever necessary. The quality of the service was audited to ensure best practice was adhered to.
- The Trust Heart Failure Team provided care and treatment in line with NICE Clinical Guidelines 108 Chronic heart failure: Management of chronic heart failure in adults in primary and secondary care.
- The service was led by a Clinical Lead and supported by Clinical Nurse Specialists who were able to prescribe.
- Individual care records confirmed that the Heart Failure Nurse Specialists were working to national guidance and that they were in regular communication with the patients' GP.
- Staff in the musculo-skeletal (MSK) service were working with academic and research staff from Keele University on a Back Start Programme which aimed to develop a needs led service with early intervention. Staff were trying to ensure that the service was available county-wide.
- Teams had a regular agenda item for their team meeting to update staff about new or amended NICE guidelines and best practice recommendations.
- The trust provided an excellent hand injuries service run by British Association of Hand Therapist level 3 trained occupational therapy staff.

Nutrition and hydration

- During 2013/2014 100% of patients who met the trigger threshold from the nutritional screening tool were referred to the Nutrition and Dietetics Team (up 29% on the previous year).
- The Speech and Language Therapy (SALT) team were also working with care staff and chefs from local care homes to improve food and reduce choking risks for people with dysphagia.
- We observed that when nurses visited patients in their own home they encouraged them to increase their fluid intake by reminders, making a drink and providing information about the risks of dehydration.
- Staff had access to a dietician who was consulted for patients who had been assessed as being at high risk of malnutirion.
- The dieticians provided education and awareness raising for staff as well as direct assessment and care for patients. They had held a trust wide nutrition and hydration week and joined the Hospital Caterers Association in their initiative 'Tea Parties Across the World'.

Approach to monitoring quality and people's outcomes

- The trust was very proactive in monitoring the quality of outcomes for patients and using the information to drive improvements.
- The trust showed that it routinely monitored patient outcomes at local and service levels and could demonstrate that some of the trust services provided better patient outcomes than other similar or alternative services. The hand clinic was a good example of this.
- We were provided with information that showed the average time taken for the single point of access (SPA) to respond to calls about patient's urinary catheters. The average speed of response to calls between April 2014 and December 2014 was less than two minutes.
- This quality monitoring was part of a CQUIN target set by the commissioners and was used to inform future service development.
- Community teams used the safety cross as a method of measuring patient outcomes and identifying trends across their service.
- The Practice and Quality Management Strategy (PQMS) tool had been finalised and provided a methodology for community divisions to assess their performance against key indicators.
- The podiatry service had key performance indicators that included four weeks from referral via the call centre to initial assessment and treatment. The service was 86% compliant against a target of 95% compliance but was showing steady improvements following a period of staff sickness and staff leaving. There was sound evidence that the trust would reach and be able to sustain target KPI by March 2015.

Good

Are services effective?

- The podiatry service had a different Key Performance Indicator (KPI) for urgent referrals of 5 days from referral to assessment and initial treatment. The service met this target 100% of the time and had done since October 2014.
- A continual Observation Log was maintained by the podiatry service. This included case studies and patient outcome information to ensure the team was providing qualitative evidence based treatment when the cohort size was too small for quantitative research and data to be statistically significant.
- The hand clinic benchmarked their results against results where a patient had seen a GP for the injury. The early results from the audit showed better results where the patient had attended the hand clinic where they were seen by an occupational therapist as well as their GP.

Competent staff

- Bank staff were well supported with many working with the same team over an extended period. A checklist was completed for all bank nurses prior to them commencing work. This checklist included ensuring that the manager helped the bank nurse plan their workload and provided a debrief and handover at the end of the shift.
- Clinical Supervision was a mandatory requirement for clinical staff.
- It was a requirement of the Quality Schedule to undertake an annual audit to evidence whether clinicians are currently receiving Clinical Supervision. The aim of this audit was to evidence the percentage of staff undertaking clinical supervision, including the number of episodes and to develop actions to improve compliance with the policy, where necessary.
- A range of training over and above mandatory training was available to staff working in community health services. This included role specific training such as catheterisation and bladder screening and training for personal development and management development.
- For the SPA, 100% of staff had received call framework training for the call type that they handle.
- The NHS Staff Survey 2014 showed that the percentage of staff who received job-relevant training, learning or development in last 12 month had not changed from 2013 and was better than national average.
- Community teams had a dementia link nurse to raise awareness and share learning in the care of people with cognitive impairment.
- The unscheduled team did not recruit any newly qualified nurses as they could not offer good preceptorship and they felt that some experience was necessary to meet the demands of the job effectively. All nurses recruited had a community nursing qualification and/or a background in an urgent care setting.
- HCAs were being trained as Band 4 Assistant Practitioners to undertake some work in the community nursing teams. Until they took up post the service was over establishment for Band 5 registered nurses.
- A competency framework had been developed with specific skills that could be undertaken by the Band 4 staff when they qualified. There were specific aspects of care that they would not be allowed to undertake including end of life care and complex wound care.
- Registered nurses had time built into their workload to enable them to retain professional oversight of the care provided by the Band 4 staff through joint visits.
- A high proportion of staff working across the community services were offered annual appraisals and performance development reviews (PDR). In podiatry, for example, 100% of staff had a completed PDR.
- A bank nurse was being employed in the wound clinic and although they had worked in the clinic for some time there was not oversight or management support for them.
- There were sometimes high levels of agency staff being used in some teams. This increased the risks associated with a lack of continuity of care and staff simply not turning up.

Multi-disciplinary working and coordination of care pathways

- Across all services we saw evidence of good MDT working within the trust and with external agencies and involved professionals.
- We observed that the continence nurse made a referral to patient's GP for review of medication after a bladder scan revealed that constipation was likely to be a contributing factor.
- We also saw that the continence service staff undertook a skin assessment and made referrals to the community nurses, if necessary, for management of pressure damage.

Good

Are services effective?

- The Older Persons Unit (OPU) provided an excellent example of multi-disciplinary working that resulted in admission avoidance for many elderly people. The unit was staffed by a consultant geriatrician, a project manager, an advanced nurse practitioner and a healthcare support worker. They were supported in the unit by onsite physiotherapy and occupational therapy staff and ambulance staff from the St John Ambulance who all worked together to try and get patients home, whenever safe and appropriate.
- A local GP practice we spoke with described the community nursing service as, "fantastic, incredibly responsive and really good to work with."
- The Trust Heart Failure Team held weekly MDT meetings.
- All calls from the local ambulance trust were put through to trust services via the unscheduled care team. An analysis of patient outcomes showed that of 200 referrals made by the ambulance trust, only 11 people were admitted to hospital.

Access to information

- Heart failure patients could access advice via an email helpline with a guaranteed response within 72 hours.

Consent and MCA

- Staff we spoke with had a very clear understanding of their responsibilities in relation to the Mental Capacity Act 2005. They were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision. One member of staff cited the example of where they had provided support to a person who wanted to return to their own home despite misgivings by their family.
- Where a person lacked consent an assessment was made and recorded: Best interest meetings were held and discussions with family members were recorded.
- The electronic recording system incorporated a drop-down box to record whether people had consented to having information about them shared with other involved professionals or external organisations such as their GP practice. Consent was also required before information from external agencies was sought.
- Direct observation of care showed us that staff across community healthcare services routinely sought verbal consent before providing any care or treatment.
- We observed one of the continence team who carried out an assessment of capacity on a younger adult with learning difficulties and then sought their consent before a bladder scan was performed.
- Where people were not able to give consent, there was evidence of discussion and consultation with family members. MDT best interest decisions were recorded.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Patients and carers we spoke with were overwhelmingly positive about their experience of care and treatment, and that feedback gathered by the organisation showed very high levels of satisfaction.
- Patients said they felt treated with dignity and respect, and that they were involved in the planning and delivery of care to the extent they wished to be.
- We saw several clear examples where staff had done more than was actually required to ensure patients received good care. People were encouraged to self-care whenever possible and independence was promoted but the staff were readily available to step in with assistance and support when necessary.
- Data collated as part of the Friends and Families tests showed entirely positive responses.

Detailed findings

Compassionate care

- Feedback from the Friends and Families Test (FFT) was collated by individual service and team. Between October 2014 and February 2015, the FFT showed a minimum of 90% of respondents were extremely likely or likely to recommend the service provided. The overall results for community health services are shown in the chart below.
- FFT for podiatry was consistently 100% with a high response rate.
- The OPU had a 99% positive response to the FFT.
- The Home Enteral Nutrition Service (HENS) asked patients to complete the FFT scorecard and were able to tell us that they had never had a negative comment.
- Feedback from patients' letters and cards showed that they valued the care that they were given and had received compassionate and kind treatment from the community healthcare staff.
- We spoke with patients across the service who all told us they were very happy with the service that they received.
- One person who had attended the continence clinic told the nurse that they had been very nervous and had never mentioned, "The problem" to anyone. They said that the nurse had been so lovely, understanding and reassuring that they had not been embarrassed at all.
- We heard about a patient who had been seen in the OPU, who wanted to return to his own home after treatment and care had been arranged. The patient had presented as hungry and emaciated. Staff on the unit found sufficient food and drinks to make a hamper for the patient to take home until their son arrived from overseas late the next day.
- Another patient was distressed when the community nurse arrived. They had been given a hospital appointment for early in the day to have an injection and were worried about how they would get to the hospital in time as they took a long time to get ready in the morning. The nurse told them not to worry and rang to cancel the appointment telling the patient they were not well enough to travel to hospital and that they would come back and do it once they had arranged a prescription.
- We heard about the St John Ambulance crews who were contracted to provide transport for patients attending the OPU. They ensured that patients were settled in at home, made cups of tea and telephoned the OPU to let them know they had left the person and that all was well.

Dignity and respect

- We observed that the curtains were drawn around the area of the gym where consultations were taking place.
- Lavatories had lockable doors and also had a curtain that could be drawn across to afford increased privacy to people that needed the assistance of a staff member when in the lavatory.
- Where family members attended as chaperones, to provide emotional support or to act as an interpreter, staff were very careful to maintain the patient's privacy. We saw that in the continence clinic additional curtains were used to screen the patient being examined from the accompanying relative or friend (if wished).
- Staff working in the OPU were very conscious that the unit did not provide segregated consulting spaces.

Good

Are services caring?

Curtains were used around the bays in the main assessment area and staff ensured that men and women were not seated directly opposite each other. There was usually only one person being seen at any time so the problem rarely arose. If sitting in a mixed gender area was an issue staff could accommodate the person in a single room.

- Patients attending the OPU were encouraged to remain dressed during their assessment time on the unit.

Patient understanding and involvement

- Patients that we spoke with were very positive about the Musculoskeletal (MSK) service they received. All reported being very involved and well informed about their treatment plan. Specific comments made included, "I have been everywhere and the only people who have done anything useful are the Loughborough physiotherapists. They operate a very high standard. I would give them full marks." Other patients mentioned how well the physiotherapists had explained everything and one said they were pleased they got a copy of the letter to their GP without asking.
- We observed that where a patient was unable to be actively involved in the planning of their care, or where they wanted additional support, that the Heart Failure Nurse Specialists involved family members with the patients' consent.

Emotional support

- The community nurses often provided care for people approaching the end of their life. We observed that they sought consent to discuss the patient's symptoms and anxieties and also whether the patient was happy for the spouse or other relative to be party to the discussions.
- Detailed explanations were given about the potential for distressing symptoms such as a massive haemorrhage and practical steps taken to help the family deal with this (such as dark coloured towels). Difficult discussions were not avoided, unless this was the wish of the patient.

Promotion of self-care

- There was evidence that trust staff from different areas of community health services promoted a culture of self-care. For example, a trust leaflet was given to patients at risk of pressure damage (or their family/ carers) giving detailed information on the prevention, recognition and management of pressure damage.
- The podiatry service was pro-active in promoting self-care and had recently developed protocols for the risk assessment and self-management of warts using silver nitrate sticks.
- The podiatry service also encouraged people to self-treat using over the counter remedies where it was felt appropriate following assessment.
- The continence service very much promoted self-care and involvement in decision making. People were given options and advice about lifestyle changes, medication and changes to equipment and accommodation to promote continence rather than incontinence.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The service reconfiguration had allowed the trust to review the most appropriate response to patients needs and provide the services to meet these. We judged the trust provided a good, responsive service.
- The demographics of the population served by the trust showed an ethnically, culturally and religiously diverse population, particularly in the city. The trust had worked had to meet the needs of the communities it served not just as cohorts with shared backgrounds or beliefs but as individuals with personal preferences. The trust provided good face to face interpreting services; the staff understood the limitations of professional translation and could explain that some people actually preferred a family member. The continence service in particular was clear that some women preferred to be accompanied by a daughter who could translate rather than have another stranger be party to an intimate conversation.
- Services were delivered close to people's homes with flexibility built into the system to allow people appointments at clinics of their choice where this was not the nearest location. We were given examples of people going to podiatry services near their work and appointments being booked so that a daughter and mother could attend at the same time.
- The self-referral system operated in some areas of the service reduced the number of people not attending appointments. We were also told that this allowed people to refer themselves with small problems like painful corns that if treated effectively reduced the need and costs for Musculoskeletal (MSK) services later.
- The OPU, the split of planned and unscheduled care and the virtual wards were exemplars of responsiveness. The system was still being developed and was due to become even more integrated in phase two of the local health and social care economy but was already highly responsive to the needs of the frail elderly, in particular. People were cared for in their own homes, the risks to the elderly associated with an admission to an acute hospital accident and emergency department were reduced and people received the treatment they needed in a timely manner. The unscheduled care team and virtual ward could have visited, assessed and started providing intravenous antibiotics or other treatment and care within two hours.
- There were very few complaints related to community healthcare services. Where concerns were raised they were responded to appropriately and there was evidence of service wide learning.

Detailed findings

Service planning and delivery to meet the needs of different people

- We saw a very individualised approach to care provision across all services that we visited. Staff were encouraged to innovate and find solutions. For example, the Speech and Language Therapy team (SALT) had worked with local communities to identify the herbs and spices they used at home to flavour their food and used this information to create a culturally acceptable pureed food menu.
- We were told that interpreting services were available for 47 languages. Staff we spoke with could cite examples of when they had used an interpreter.
- The trust interpreting service could provide face to face interpreting, telephone translation via language line and sign language interpreting.
- Staff also told us that whilst they offered to provide a professional interpreter, some patients felt more comfortable with a family member providing this service and that this would be respected.
- The trust provided a county and city wide Home Enteral Nutrition Service (HENS) that supported people reliant on tube feeding to be discharged home safely and monitored how they were managing post discharge. The team could provide services that might otherwise necessitate a hospital visit such as balloon and other gastrostomy changes and naso-gastric tube replacement. The service was available Monday to Friday 9.00am to 5.00pm.
- The continence service was flexible and covered a wide population with clinics, home visits and visits to care homes.

Good

Are services responsive to people's needs?

- We observed the care of a younger adult with learning disabilities by a member of the continence team and saw that they were treated with full consideration of their needs. Comprehensive explanations were given in a manner that could be understood by the patient.
- We heard an example of where the podiatry service staff had, 'Gone the extra mile' to ensure patient's religious beliefs were considered and supported. The patient did not use alcohol in any form because of their beliefs so the staff had sourced skin cleaning lotions for nail surgery that did not contain alcohol.
- We saw that patient appointment dates had been changed or the timings of appointments amended to support patients who were fasting during Ramadan and who needed a local anaesthetic.
- Services were provided close to people's homes. Podiatry for example, was provided from 37 locations.
- Self-referral by 95% of people attending the podiatry clinics resulted in very high attendance rates. Data from the managers of the service showed that people turned up for appointments they had requested far more often than when a professional made the referral.
- The service sent mobile phone text reminders to people which also resulted in an increased attendance rate. Where consent had been given, reminders were also sent to the relatives or carers to encourage them to remind people to attend on the day. The 'Did Not Attend' rate had fallen from 11% to 5-6% since introducing text reminders.
- The continence service provided 'block bookings' to care homes where there were several people living who required specialist input in the management of incontinence. Staff from the trust undertook comprehensive assessments for individuals living at the home and also provided education for staff.
- In all the buildings we visited as part of the inspection there were accessible facilities for people with mobility difficulties.
- Breast feeding facilities and baby changing areas were available in the premises we visited.
- Two specialist mental health Speech and Language Therapists were working with a number of care homes to improve the way they supported people with dementia to communicate.
- The SPA for the community nursing teams had introduced an automated call back system where patients would previously have needed to wait in a queue, they could now leave their telephone number and they would be called back once a call handler became available which meant they would not lose their place in the queue.

Access to the right care at the right time

- There was a whiteboard posted outside the gyms at Loughborough Musculoskeletal (MSK) service which showed classes were available seven days a week.
- Two patients we spoke with mentioned the flexibility offered when booking appointments. One said, "The front desk staff are very helpful and have been flexible in booking around my work."
- Physiotherapy staff told us that they had used a staffing capacity analysis tool to enable them to gather accurate information so they could make best use of new patient slots across the county.
- We were told the trust had recently invested in waiting list reduction strategies for MSK services. Patient referrals were triaged with high priority patients target set at a two week maximum. The service was currently meeting this target in 95% of cases.
- The MSK service had also met the 4 week wait from referral to treatment for less urgent cases across the trust area.
- When we visited a patient in their own home with a community nurse they asked the nurse to come back later as they were busy. The nurse accommodated this request.
- Many of the services offered within community healthcare allowed self-referral by patients as well as more traditional referral routes. This included podiatry, continence services and MSK services for long term conditions.
- A series of virtual wards had been set up across Leicestershire and Rutland counties and Leicester city to accommodate the patients with greatest needs in their own homes, thus avoiding hospital admission. Patients with acute exacerbations of long term conditions or who needed intravenous antibiotics could be visited by community nurses up to four times a day. If necessary, a night sitter could be arranged and staff were employed to provide social care that bridged the time from referral to delivery via the local authority. The virtual wards developed as part of the 'Better Care Together', a blueprint for Health and Social Care in Leicestershire, Leicester and Rutland 2014-2019.

Good

Are services responsive to people's needs?

- The Virtual ward was available to people living in care homes.
- The community nursing service had split planned and unscheduled care to improve patient care. The planned team provided routine and ongoing care through scheduled visits without the disruption caused by telephone calls and the need to rearrange their visit order to attend patients with more urgent needs.
- People requiring an unscheduled urgent visit could be seen within twenty minutes, if necessary. The service was described as being, "The front door to the community nursing service. You would not leave your front door unanswered."
- The trust provided data which showed in November 2014 referral to initial assessment waiting times for patients with long term conditions were 24 days on average for routine (non-urgent) referrals and eight days for urgent referrals. The target waiting times for routine referrals was 4 weeks and for urgent referrals was 2 weeks; the services met both waiting targets for routine and urgent referrals.
- Therapy services sat alongside community nursing teams and also had a scheduled and a planned service with staff working across both services.
- The Trust Heart Failure Team provided an email service with a target response time of 72 hours which could be accessed by patients and GPs.
- A single point of access (SPA) was set up for the Leicester City Clinical Commissioning Group as a nurse led community triage point and had grown into a countywide SPA for community nursing services. The second phase of the service development will bring other community health services (such as podiatry) into the same system.
- The podiatry service currently had their own SPA that accepted referrals from across the geographical area provided by the trust.
- The SPA had a priority system for GPs contacting about requests for urgent visits.
- The podiatry service provided a training package for care homes and long stay community wards to encourage supported self-care whenever possible.
- The podiatry service had a 'Diabetic Hotline' for people with foot wounds. The service aimed to see the patient within 24 hours and could issue antibiotics under a Patient Group Directive, if necessary. They were also able to make a direct referral to the acute hospital services if necessary.
- The OPU accepted referrals from nursing and residential homes for review. These patients were usually discharged back to their care home with appropriate medication or treatment having been arranged.
- We found there was a backlog of patients awaiting diabetic review in the city. These reviews were undertaken by the phlebotomists who told us they did not have sufficient work hours to complete these in a timely manner.
- Patients referred to the hand clinic were seen within one week for acute problems and four weeks for routine referrals.

Discharge, referral and transition arrangements

- The OPU had identified a problem in getting a swift discharge home for patients who attended the unit due to delays in transport being available. The trust had resolved this by contracting with the St John's Ambulance to provide a bespoke transport service for people attending the OPU. An ambulance was available from 1pm each afternoon to take people as soon as they were ready to go. The ambulance staff settled people in at their homes and ensured they were safe to leave.
- A patient using MSK services told us that they had been referred by their GP and been seen within a week. They felt this was very good.
- We saw that regular reviews of care were booked into the patient information system, which confirmed what nursing staff had told us. The reviews always considered whether a patient could be discharged from the community nursing team.
- People accessing the rapid discharge programme from the acute hospitals were reviewed by the Virtual Ward team at their morning board rounds. The team had excellent links to the specialist palliative care team and could provide an immediate service for patients who were choosing to die in their own home.

Complaints handling and learning from feedback

- At the trust locations we visited there was information about the Patient Advice and Liaison Service (PALS) displayed in public areas.
- MSK service staff were able to demonstrate that they had made a change in response to complaints around long term patients being discharged and having to go back to their GP if they had further problems. The service now allowed self- referral for long term problems.

Good

Are services responsive to people's needs?

- Patients had information about making a complaint in the personal care plans kept in their homes.
- We saw that one therapy team successfully resolved a complaint locally. We were also told the team had received feedback following the successful complaint resolution. The feedback included the need to report all complaints centrally so that trends could be identified and responses across the service were consistent.
- The OPU had not had any complaints since opening.
- The unscheduled care team had no outstanding complaints.

Good

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 rated well-led as good because;

- There was a very clear vision and strategy for the service that was known to most, if not all, of the staff we spoke with. Some staff told us they had been involved in the development of this and all saw the recent restructuring as positive, with real benefits for patients.
- Each service lead and manager that we spoke with could articulate very clear governance and risk management systems and processes for their area. Managers highlighted what was on their risk register to us and could detail the steps that were in place to mitigate against those risks. The organisation was developing quality measures and used performance data to drive service improvements. We could see this working in practice with staff able to tell us about changes and 'tweaks' to their way of working when things were not quite right. Governance was very much seen as the responsibility of the whole service and also of every staff member; it was not something done to staff but rather something done by staff.
- Culturally, the service as a whole, the teams within the service and individual staff were very positive and forward looking. They had exciting ideas they wanted to introduce; they wanted to grow and develop their own areas of practice. We saw a clear shared vision and a culture that built on the positives of the change. Staff told us the trust was a good place to work, that they were happy and felt the restructuring had bought many benefits. Staff smiled a lot and went out of their way to talk to us about the work they were doing and how proud they were of it.
- Staff told us that they felt their managers were approachable and that they listened. Some described an open door policy at local level. Some talked about being supported and empowered to grow and develop new skills. When we spoke with managers and service leads we felt their excitement and commitment to the services they led. They were passionate about how the provision was continuing to improve and talked about what their next steps were.
- There were many examples of innovation which had been introduced to increase the sustainability of the services and improve access for patients. Services remained clinically led and all members of staff were encouraged to share ideas for improvements.

Detailed findings

Vision and strategy for this service

- At the trust locations we visited, information about the trust values and vision was displayed.
- Staff had recently been provided with a credit card sized Visions and Values cards.
- The Integrated Community Response Service (ICRS) was part of the countywide cross sector blueprint for health and social care, 'Better Care Together'. Phase one of this initiative had seen community services working more closely with social services and mental health services. The model had proven to be very successful with the local authority doubling their social care capacity to support the scheme,
- We were told that from May 2015 all agencies providing support will be co-located.

Governance, risk management and quality measurement

- Service and team managers we spoke with had a clear understanding of the performance of their team and the individuals within this. Several managers could give us statistics about compliance with training and supervision without reference to documents.
- The trust had developed a call assessment quality framework and associated standards which was reviewed, agreed and signed off by Commissioners.
- The Clinical Supervision Re-Audit 2014/15 (Community Health Services report dated January 2015) demonstrated that the local managers and more senior trust managers were monitoring staff performance against key indicators. Where shortfalls were identified an action plan had been created to ensure these were addressed by individual teams and also across the wider trust.

Good

Are services well-led?

- The MSK service used a patient outcome monitoring system to measure the effectiveness of their service, the Patient Recorded Outcome Measures (PROMs). People were asked to complete a form pre and post treatment and these were then collated and used to inform service development.
- We saw evidence of audits of Health and Safety at Loughborough hospital. We were shown evidence of action taken in response to an audit dated 4 December 2014 which included purchasing chairs with armrests and higher seats for the waiting area.
- The trust publishes a leaflet, 'Clinical Governance: What does it mean for us all in our trust?' This leaflet makes explicit the reasons that sound governance systems are important and the responsibilities of individual staff members.
- The manager of the SPA undertook a 'Task and Finish' group assessment to determine whether the outcome for patients was different when a nurse took the initial call as opposed to a non-clinical call handler. The results showed there were no significant differences so more non-clinical call handlers were employed, freeing nurses to manage visits.
- We saw evidence of appropriate performance management where there were concerns about the practice of an individual staff member. The concerns were investigated fairly and fully with support and additional training being provided before competency proceedings were commenced.
- Teams could tell us how they were doing. For example, the nurses working out of Westcotes Health Centre could tell us they had been 95 days with no avoidable pressure wounds.

Leadership of this service

- The NHS Staff Survey 2014 showed that the percentage of staff reporting good communication between senior management and staff had not changed from 2013 and was better than national average.
- One nurse manager was described by their team as, "Visible, dynamic and pro-active." Another manger was described as," supportive and listening."
- The trust had a Dignity at Work helpline for staff.
- The SPA is led by a non-clinical operations manager with a call centre background who works with a clinical lead for service development.
- The community nursing teams were using the NHS Institute for Innovation and Improvement programme, 'Releasing time to care – the Productive ward'. The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.
- The majority of staff we spoke with were positive about their relationships with their line managers. They said their immediate managers were approachable and effective. We observed good interactions between team leaders and their staff.
- We heard that the executive team made visits to community teams sometimes and that the Head of Nursing was, "Visible, dynamic and pro-active."
- Staff knew who the Director of Nursing was and managers said they could raise concerns to senior managers, if necessary.
- There was evidence that the Director to Nursing (DoN) provided support to senior and middle managers in a tangible way. We were given an example where the DoN had stepped in to assist a manager in resolving an issue about referrals being made for home visits to patients who were mobile.
- The executive team and board visits included a visit by the Chair of the board to the Single Point of Access call centre. Whilst on site he also took the opportunity to visit the unscheduled care team.

Culture within this service

- All staff had been given access to the Community Health Services Spirit handbook, which detailed the principles to help create the "ideal culture". This change programme was developed from listening to patient stories and a series of Staff Voices workshops. From this a cultural charter had been developed that made statements about staff and organisational behaviour and beliefs.
- Several key messages were developed from the Spirit programme including, "The spirit in which we do things is just as important as how we do them" and "Shine a light on others which is brighter than the light they shine on themselves." Numerous staff we spoke to mentioned the 'Shine a Light' message.
- A monthly professional meeting was held by the community services manager who told us there were usually 50 -70 staff in attendance.
- Many staff of all grades working in various locations talked to us about being proud of the service they provided.

Good

Are services well-led?

- We saw an organisation where staff cared for each other. Community nurses told us they phoned each other at around midday to review workloads and provide assistance to colleagues whenever possible.

Public and staff engagement

- Individual staff at all levels were encouraged to become trust Champions for Change. These roles involved lots of meetings to learn about the trust plans for development which were shared with their teams. We were told this allowed operational staff to get to know senior managers and see that the trust board was really interested in how staff felt.
- As part of the transition within community nursing services, staff were asked to decide whether they wanted to work in unscheduled or planned care teams. They were offered a six month trial to ensure it felt right for them.
- Across the service we saw several examples of where an idea suggested by staff had been considered and implemented.
- During the transitional changes and development of the Better Together blueprint the trust offered staff consultation sessions 'Staff Voices' which we heard about from many staff working in different settings,
- A separate consultation had been made with the local community, 'Community Voices'.

Innovation, improvement and sustainability

- We saw clear evidence of an organisation committed to improvement. For example, feedback from the National Health Service Litigation Agency (NHSLA) said that claims for clinical negligence related to community nursing were high in 2012/13 and then reduced in 2013/14
- The Speech and Language Therapy team (SALT) had initiated a pilot where they worked with the dieticians and staff from local care homes to identify training needs. The team then provided the training for the homes and improved the care patients received. The team had been awarded a Leicestershire Partnership Trust Excellence Award for this project.
- The Trust Heart Failure Team had started an initiative to 'grow their own;' nurse specialists. There were three Band 6 nurses on a three month induction. A competency framework was being put in place to support these nurses in developing the necessary skills for their specialist roles.
- Having shown the heart failure service to be effective at providing high quality care and good patient outcomes, the service was being expanded to other areas of the trust area and also starting to work with patients with right sided heart failure.
- The trust had purchased 300 tickets to, 'Inside out of mind' a professional play about the experience of dementia care. Teams of staff from community healthcare service were going.
- An integrated discharge team had been established working with the acute trust. Referrals were triaged to determine the timing of the response. The service was available across the whole trust geographical area.
- The podiatry service had developed an income generation projects under the 'Any Qualified Provider' Scheme. Under this scheme providers must meet the qualification criteria set for a particular service and once qualified their service will appear on choose and book for patients to select. This meant that the trust could accept patients from the areas bordering other counties (which often provided easier access to services for these patients) and also generated income for the trust.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing We found staffing was not always adequate to prevent impacts on workloads due to staffing shortages. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing. The trust must make sure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to provide appropriate care and treatment. We found bank staff had not all completed mandatory training in line with trust requirements. This was in breach of regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing. The trust must make sure people who use services and others are protected against the risks of unsafe or inappropriate care and treatment due to staff not receiving appropriate support, training and professional development as is necessary to enable them to carry out the duties they are employed to perform.