Northamptonshire Healthcare NHS Foundation Trust

RP1

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)
RP1X2	Battle House	Community Health Services for Adults	NN1 5PD
RP1P1	Willowbrook Health Centre	Community Health Services for Adults	NN17 2UR
RNQ51	Kettering General Diabetes Centre	Community Health Services for Adults	NN16 8UZ
RP1A1	St Marys Hospital Kettering	Community Health Services for Adults	NN15 7PW
RP1J5	Brackley Health Centre	Community Health Services for Adults	NN13 6EG
RNSX1	Weston Favell Health Centre	Community Health Services for Adults	NN3 8DW
RP1F2	Isebrook Hospital	Community Health Services for Adults	NN8 1LP
RP1Y8	Danetre Hospital Daventry	Community Health Services for Adults	NN11 4DY

This report describes our judgement of the quality of care provided within this core service by Northamptonshire Healthcare Foundation 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 Northamptonshire Healthcare Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire Healthcare Foundation Trust.

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
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, we rated this service as good because:

- There were processes in place to measure safety performance. The majority of patients that used community health services for adults received harm free care.
- There was a good reporting culture across most services. Staff were encouraged to report incidents and always received feedback from incidents they had reported.
- Medicines were stored securely and there were robust arrangements to manage medicines across services.
- Care was provided in accordance with evidence based guidance, standards, best practice and legislation.
- We observed effective multidisciplinary working to provide co-ordinated patients care.
- The service reported good performance in a number of national audits such as podiatric surgery.
- Services were planned and delivered to meet the needs of patients and those of the local health economy.
- Staff morale was good. Senior nurses were visible to staff and staff said they felt respected and supported by their managers and colleagues.
- The service scored highly in the trusts "I want great care" questionnaires with 94% of patients saying they would recommend the service to their family and friends.
- Staff competencies were based on best practice guidance.
- Most staff had received an appraisal.
- The intermediate care team facilitated early discharge from hospital where a health monitoring or rehabilitation need had been identified.
- Patients were treated with respect and kindness, and their privacy and dignity was protected. Patients understood their care and were involved in making decisions about their care.
- Patients were seen for an initial assessment in a timely manner once they had been referred.

However:

- Not all risks to patients and staff had been identified, assessed, monitored and mitigated. We found out of date equipment and medical consumables in storage cupboards and treatment rooms within the phlebotomy service.
- Infection prevention and control processes were not always being followed. We found a visibly dirty treatment room within the phlebotomy service and dedicated hand-washing basins contained personal items.
- Community nursing teams did not routinely monitor patients for signs of deterioration.
- Not all staff had the appropriate level of safeguarding training. Some staff were treating children within the physiotherapy and tuberculosis services without the level of safeguarding training required.
- Not all staff had received mandatory training. Mandatory training compliance did not meet the trust target of 90%.
- Not all staff had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- The podiatric surgery service did not audit the five steps to safer surgery World Health Organisation checklist.
- The phlebotomy service was not assessed or monitored. There was a lack of oversight of the service and it had not been delivered in line with the service level agreement with commissioners.
- There was no overarching strategy for planned and unplanned care. Staff had not been involved in the development of the trust strategy and not all staff were aware of the trusts visions and values.
- Some services had a high number of patients that did not attend their appointment without informing the service prior to their appointment time.
- Complaints were not always responded to within a timely manner.

Summary of findings

Background to the service

Northamptonshire Healthcare NHS Foundation Trust (NHFT) was formed in April 2001 following the merger of Northampton Community Healthcare NHS Trust and Rockingham Forest NHS Trust and achieved Foundation Trust status in May 2009. NHFT integrated both physical and mental health community services in July 2011.

NHFT provides health and social care services to the people of Northamptonshire, as well as some specialist services in bordering and nearby counties. The trust offers a comprehensive range of physical, mental health and specialist services, many of which are provided in hospitals, General Practitioner (GP) surgeries and clinics. The community services aims to deliver care to patients in their own homes whenever possible and provides many services outside of the hospitals and in the community. Their comprehensive range of services includes podiatry, physiotherapy and district nursing services. The trust's sites are located in Corby, Daventry, Kettering, Northampton and East Northamptonshire.

Community health services for adults were last inspected in February 2015. We rated the service as requires improvement overall and told the trust they should take the following actions:

- The trust should review the comprehensive discharge system between the acute services and the community services to identify areas of unsafe practice.
- The trust should ensure that local incidents are fed back to staff so that any trends or outcomes are identified and cascaded to staff.
- The trust should ensure that staff are aware of the safety thermometer and how it is used to measure harm.
- The trust should review the paper and electronic records to ensure that the recordings are accurate and do not contain variances and discrepancies.

During this inspection, we found all actions had been completed.

Our inspection team

Our inspection team was led by:

Chair: Mark Hindle, Chief Operating Officer, Mersey Care NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection CQC

The team included inspection managers, inspectors, specialist advisors and an expert by experience that had experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected this core service comprised of two CQC inspectors and two specialist advisors who had experience of working in community health services for adults.

Why we carried out this inspection

We inspected this core service as a follow up comprehensive inspection.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

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

Before the inspection visit, we reviewed information that we held about these services. We carried out an announced inspection on 23 to 27 January 2017. During the inspection we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 09 February 2017.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- The provider must ensure that all staff are appropriately trained to the relevant safeguarding adults and children level for their role.
- The provider must ensure that all patients have observations taken and documented in accordance with the Community Early Warning Scores system.
- The provider must ensure that infection prevention and control risks are assessed and mitigated across community health services for adults.
- The provider must ensure that there are processes in place to routinely monitor, assess and audit the five steps to safer surgery World Health Organisation checklist.
- The provider must ensure that there are robust systems in place to manage environment and equipment.
- The provider must ensure that the risk to the health and safety of service users receiving care and treatment, and waiting for care and treatment, is assessed.

Action the provider SHOULD take to improve:

- The provider should ensure that all mandatory training meets the trust compliance target of 90% and have sufficient numbers of suitably qualified competent and skilled staff to manage patient risk.
- The provider should ensure that all staff have complied the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- The provider should ensure that complaints are investigated and responded to within the trust's recommended timeframe.
- The provider should ensure that patients being cared for at home are informed of accurate times they will be visited.
- The provider should ensure there are systems and processes in place to manage responsiveness, risk and quality measurements across community health services for adults.
- The provider should ensure that all clinical audits are included on the trusts audit plan.

Northamptonshire Healthcare NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated this service as requires improvement for safe because:

- We found out of date equipment and medical consumables in the phlebotomy service, such as plasters and antibacterial wipes.
- Infection prevention and control processes were not always being followed. For example, some staff were using dedicated hand washing basins to clean personal items, such as cups and personal items were found on the clean phlebotomy trolley.
- Community nursing teams did not routinely monitor patients for signs of deterioration.
- The podiatric surgery service did not audit the five steps to safer surgery World Health Organisation checklist.
- Not all staff had the appropriate level of safeguarding training. Some staff were treating children within the physiotherapy and tuberculosis services without the level of safeguarding training required.

However:

- Infection prevention and control issues had been addressed when we carried out an unannounced inspection.
- Safety performance was measured and discussed at service team meetings.
- The majority of patients that used community health services for adults received harm free care.
- Most staff were aware of their responsibilities to report incidents and there was a good reporting culture across most services. Staff were encouraged to report incidents and always received feedback from incidents they had reported.

Requires improvement

Are services safe?

- Staff knew how to raise a safeguarding concern and who the trust's safeguarding lead was if they needed to contact them.
- There were appropriate arrangements in place to manage medicines across services and in patient's homes.
- Records we looked at were accurate and up to date.
- Anticipated risks were managed. Staff were aware of how lone working processes had been adapted for their individual service and adhered to the lone working policy.

Safety performance

- The safety performance of the community nursing team was measured by using the NHS Safety Thermometer. The NHS Safety Thermometer is a tool used to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections and venous thromboembolism (VTE). A VTE is the formation of blood clots in the vein. The NHS Safety Thermometer results were not displayed for teams to see however, we saw evidence of safety thermometer results being discussed at district nursing team meetings.
- From December 2015 to December 2016, the NHS Safety Thermometer results for community nursing were:
  - The average percentage of patients who received harm free care was 94%, which was the same as the national average.
  - The average percentage of patients who acquired a new grade two, three or four pressure ulcer was 1%, which was the same as the national average.
  - The average percentage of patients who had come to harm as a result of a fall was less than 1%, which was the same as the national average.
  - The average percentage of catheterised patients who had acquired a new urinary tract infection was less than 1%, which was the same as the national average.
  - The average percentage of patients who acquired a new VTE was less than 1%, which was the same as the national average.

Incident reporting, learning and improvement

- Most staff we spoke with understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses. Staff were encouraged, and were confident in doing so, to report incidents via the electronic reporting system and said they always received feedback via email.
- Phlebotomy staff we spoke with gave examples of incidents that had occurred in clinics but said they had never reported them on the electronic system. For example, staff we spoke with had not reported when a patient fainted after having their bloods taken. This was highlighted to a senior manager on inspection. During our unannounced inspection, staff said they had since been trained on the electronic incident reporting system and knew how to report incidents that occurred in phlebotomy.
- There had been no "never events" reported from October 2015 to September 2016. A never event is described as a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- There had been two serious incidents that required investigation from October 2015 to September 2016. One of which related to management and leadership issues within a district nursing team, which was due to be downgraded following investigation. The other incident was an acquired grade four pressure ulcer of a patient under the care of a district nursing team.
- There were a total of 2,198 incidents reported via the electronic reporting system from October 2015 to September 2016 that were attributable to Northamptonshire Healthcare NHS Foundation Trust (NHFT) and an additional 588 incidents were reported which were attributable to other organisations.
- Incidents were categorised by severity. Of the 2,198 reported incidents attributable to NHFT, 447 resulted in

no harm, 1,438 incidents resulted in low harm (65%), 301 resulted in moderate harm (17%), five resulted in severe harm (<0.1%), and seven resulted in death (<0.1%) (not caused by a patient safety incident).

- The most commonly reported incident was grade two and three pressure ulcers.
- Staff were involved in incident investigations and learning from incidents was shared at individual service meetings and we saw evidence of incidents being shared across different localities.
- The trust was implementing a 'Sign up to Safety' campaign to reduce avoidable harm to patients by 50%. The aim of the campaign is to show improvements in the following:
  - early detection of the deteriorating patient
  - reduction in avoidable pressure ulcers
  - reduction in harm from falls
  - reduction in unexpected death
  - reduction in use of restraint
  - reduction in omitted doses of medicines
- Staff within the podiatric surgical service informed us they were looking at creating National Safety Standards for Invasive Procedures (NatSSIPs). NatSSIP was published in September 2015 to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical never events can occur. The NatSSIPs bring together national and local learning from the analysis of never events, serious incidents and near misses through a set of recommendations that will help provide safer care for patients undergoing invasive procedures.
- As of April 2016 all patient safety alerts were issued by NHS Improvement. Patient safety alerts provide guidance on preventing potential incidents that may lead to harm or death. These incidents are identified using a reporting system to spot emerging patterns at a national level, so that appropriate guidance can be developed and issued to protect patients from harm. We saw folders within the community services outlining directives which included for example, an alert regarding antiviral medicines and the withdrawing of insulin from pen devices.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw guidance within the service, which staff used as a reference.
- Senior staff were aware of the duty of candour regulation. Staff we spoke with across all services were aware of the requirement to be open, honest and transparent when an incident occurred however most staff we spoke with were not familiar with the 'duty of candour' term.

Safeguarding

- Staff were able to demonstrate how they would report safeguarding concerns. Staff were encouraged to discuss concerns with the trust's safeguarding team. District nurses we spoke with said they were also given the opportunity to discuss safeguarding concerns at their cluster meetings.
- There was a new planned care initiative whereby a bulletin was circulated to staff quarterly. This included safeguarding information and lessons learned from safeguarding concerns.
- The trust attended a Multi-agency Risk Assessment Conference (MARAC) that took place six times per month. The aim of the MARAC meetings was for a range of agencies such as the police, healthcare services and child protection, to share information and increase the safety and wellbeing of domestic abuse victims and their children by developing and implementing a risk management plan that provides professional support to victims.
- Safeguarding for children and adults level two training compliance was 91%. This exceeded the trust target of 90%. However, only 88% of the required staff had

received safeguarding for children and adults level one and 56% of the required staff had received safeguarding for children and adults level three. This did not meet the trust's compliance target of 90%.

- Some staff did not have the appropriate levels of safeguarding training for the services they delivered. For example, within the physiotherapy and tuberculosis services, staff treated to children, young people and babies with level two safeguarding children training. There was no risk assessment for this practice. This meant that staff did not have safeguarding training relevant for their role to appropriately protect patients. This concern was escalated to the trust on inspection and to a senior manager on our unannounced inspection.
- Community nursing staff received monthly safeguarding supervision with their line manager.
- District nursing staff confirmed they had undertaken PREVENT training. However, this was not identified in the figures provided by the trust which showed that only 20% of trust wide staff had completed their Prevent training. Prevent training is a government directive to support vulnerable individuals. Prevent is the duty in the Counter-Terrorism and Security Act 2015 on specified authorities, in the exercise of their functions, to have due regard to the need to prevent people from being drawn into terrorism.
- The trust made 235 adult safeguarding referrals and 406 child safeguarding referrals from October 2015 to September 2016. The records showed that 100 adult referrals had been made and two children's referrals by the community services.

Medicines

- There were appropriate arrangements in place for managing medicines across all services and within patient's homes. Medicines were stored appropriately across all locations we visited.
- Medicine management training was undertaken yearly for all staff who administered medicines. The district nursing services did not keep any medicines on their premises. We saw staff had access to the British National Formulary (BNF). The BNF is a pharmaceutical reference book that contains a wide spectrum of information such as indications, contraindications, side effects, doses and legal classification as well as advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the NHS.
- The trust used an electronic system for recording information on medicine management. We looked at 11 records and found no issues or concerns. For example, we observed allergies were appropriately recorded in all records seen.
- We looked at 11 patient records and saw that allergies were appropriately recorded.
- The trust used a red flagging system to highlight medicines which staff were required to take special care. We saw this in use during our inspection.

Environment and equipment

- We found out of date equipment in a treatment room used by phlebotomists at Weston Favell Health Centre, such as vaginal speculums and sterile saline. We were told that the room was a shared facility with several GP practices and the equipment was not used by NHFT staff. The health centre was owned by another organisation. We found there was no service level agreement in place with owner of the health centre which meant the accountability and responsibilities were unclear of separate organisations using the building, the owner of the building and its occupiers. There was no system or process in place to ensure equipment used by the trust to provide care and treatment to patients was safe for use. This was escalated to the trust who told us that a service manager had taken the responsibility and checked through all cupboards and removed all out of date equipment.
- However, when we revisited the health centre the next day we found further out of date medical consumables in treatment rooms and store cupboards used by trust phlebotomists. Such as plasters dated 2013, disinfectant wipes dated 2014 and surgical tape dated 2015. This was escalated to a service manager during our inspection who immediately took action to have the equipment removed.

Requires improvement

Are services safe?

- During our unannounced inspection we found further out of date medical consumables. For example, a bag of vacutainers which had expired in 2016. This meant that although the trust had assured us all out of date equipment had been removed, this was not the case.
- We found a fridge used to store clinical specimens, such as blood and urine, as well as personal food items. Phlebotomy staff we spoke with told us they did not store blood specimens in the fridge during their morning clinic but said they took responsibility for removing any blood specimens that were placed in the fridge by health centre staff at the start of each shift and ensured they were sent for testing. Managers were not aware of this arrangement. During our unannounced inspection, we were informed staff were no longer taking responsibility for blood specimens that had been taken by staff from a different organisation.
- Fridge temperatures were not monitored which meant that staff were not assured that the fridge was operating at the correct temperatures.
- During our unannounced visit, we observed action had been taken and the fridge had been removed.
- Staff recognised that the stairs in the Weston Favell Health Centre were a trip hazard because the steps were uneven. This had been covered with hazard tape to indicate the risk to patients using the stairs however the hazard tape had worn and was peeling off. This in itself constituted a further trip hazard for patients using the stairs. The stairs were routinely used by patients accessing the speech and language therapy service and community nursing staff based at the health centre. This issue was not on the risk register.
- All equipment across other locations we inspected were stored safely and were in date.
- The design of most other areas and the maintenance of the facilities and electrical equipment protected people from avoidable harm. There were systems and arrangements in place to review and check equipment with the exception of phlebotomy services provided from Weston Favell Health Centre.
- We saw cleaning materials including chemicals were locked away appropriately across all sites we visited.
- We saw that sharps bins (a container that is filled with used medical needles and other sharp medical instruments, such as an intravenous catheter) were collected daily and placed in a large sharps bin outdoors which were collected weekly for incineration.

Quality of records

- We looked at a total of 11 electronic patient records across podiatry, the intermediate care team and community nursing teams. All records we looked at were accurate, up to date and stored securely electronically.
- The quality of patient care records was audited quarterly across services, such as community therapy, hand therapy and heart failure services to ensure records were up to date and contained the relevant patient information. The results from April to June 2016 were:
  - Community heart failure specialist nurses scored 100% overall.
  - Community therapy services scored 99% overall.
  - Hand therapy services scored 93% overall.
  - Podiatry services scored 85% overall.
- We saw evidence of action plans following records audits. Hand therapy audits showed that staff were not routinely completing patient's personal details such as their next of kin, marital status and ethnic origin. Action had been taken to address the issue and the service had since adapted patient consent forms to ensure they captured these details.
- Senior staff confirmed they were reviewing the areas identified as concerns within podiatry records which were; the lack of patient information regarding their religion and ethnicity. Staff confirmed this had been addressed at team meetings.

Cleanliness, infection control and hygiene

- The trust undertook Patient-Led Assessments of the Care environments (PLACE). PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and are made up of at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as

well as supporting non-clinical services such as cleanliness. For example, we saw that Isebrook Hospital and Danetre Hospital had scored 99% and 100% respectively. This was higher than the England average of 98%. However, we found poor cleanliness when visiting the phlebotomy services at Weston Favell Health Centre.

- Infection prevent and control audits including personal protective equipment and hand hygiene audits were completed across services. For example, in October 2016, hand hygiene audit results were 100% for the Weedon community nursing team.
- We found infection control issues at Weston Favell Health Centre. For example, in a treatment room used for phlebotomy, there were two sinks however, one sink was inaccessible and was obstructed by a broken bed which was not in use. The sink that was in use contained dirty personal items, such as mugs and spoons. Staff used the same sink for both personal use, to clean personal items, and clinical use, to wash their hands. This did not meet the Department of Health best practice guidance: Health Building Note 00-99 – Infection control in the built environment (March 2013) which recommends that all clinical areas should have a dedicated clinical wash-hand basin and that all wash-hand basins should be accessible.
- During our unannounced inspection, the second sink was still obstructed by the bed and action had not been taken to remove it. A senior manager told us the bed was in the process of being removed.
- We also found a pair of shoes situated on the clean trolley used for phlebotomy, which meant there was a risk that items on the phlebotomy trolley could become contaminated. This was escalated to senior management who took action to immediately remove the shoes and have the clean trolley deep cleaned.
- One of the treatment rooms used for phlebotomy was visibly unclean. We escalated this to the trust who informed us a deep clean had been undertaken. We re-inspected both treatment rooms the following day and a deep clean had not been undertaken. The treatment room, skirting boards and hand washing basis were still visibly unclean.
- During our unannounced inspection we observed the treatment rooms used by phlebotomists had been deep cleaned and we found no concerns with the cleanliness of the environment.
- Most staff we spoke with were aware of the trust's infection control policy and where it could be located. We observed that staff were bare below the elbow of the arm. Staff had access to personal protective equipment (PPE) which included gloves and aprons. Staff carried the relevant PPE as well as hand sanitising gel when visiting patients at their homes.
- During our last inspection in February 2015, there were environmental issues at the Highfield Clinical Care Centre, such as reports of damp, damaged walls and pain peeling off pipes. During our recent inspection we found that all environmental issues had been resolved and the care environment was well maintained.

Mandatory training

- Community health services for adults had an overall compliance rate of 80% which did not meet the trust target of 90%. Training records showed that staff working across community health services did not meet the mandatory training compliance target for seven out of 15 training courses. Examples included:
  - fire safety training was 81%.
  - infection prevention and control level two training for clinical staff was 86%.
  - resuscitation level two training (basic life support) was 77%.
  - safeguarding adults and children level one training was 88%.
  - safeguarding adults and children level three training was 57%.
  - manual handling level two training was 71%.
  - resuscitation level three (intermediate life support) training was 81%.
- Training records seen within the podiatry service showed they had achieved 100% in their service specific mandatory training which included; immediate life support, anaphylaxis (an acute allergic reaction to an

antigen, such as a bee sting to which the body has become hypersensitive), health and safety, Mental Capacity Act 2005 (MCA) and safeguarding adults level two.

Assessing and responding to patient risk

- The specialist diabetic team completed glycated haemoglobin (HbA1c) tests. HbA1c develops when haemoglobin, a protein within red blood cells that carries oxygen throughout the body, joins with glucose in the blood, becoming "glycated." By measuring the HbA1c, the diabetic team were able to assess and respond to the patient's average blood sugar levels over a period of weeks/months. The trust had a policy for the administration of insulin in the community by health care assistants however the trust told us the policy does not specify how to manage the administration of insulin for paid and unpaid carers as this is the responsibility of the care agency.
- To promote and respond to patient risks the district nursing service was promoting patient's independence with the management of their diabetes. This involved the review of medicines, and the assessment of their lifestyles and diet. Patients were encouraged to keep diaries and liaise with the specialist diabetic team.
- Community nursing teams within planned care were not using early warning scores in line with trust protocol. Early warning scores are commonly used for the assessment of unwell patients; these observations can detect when a patient's condition requires more intense observation and should be a trigger for further investigation and action, as early intervention can reduce morbidity and mortality in unwell patients. The trust had developed The Community Early Warning System (CEWS) to detect the deteriorating patient's physiological changes and request medical intervention before the patient's condition started to show actual visible signs of deterioration. The trust protocol to detect the deteriorating patient stated "It is the responsibility of the Registered Nurse designated to the patient to ensure that observations are undertaken and documented in accordance with the CEWS. Medical Staff and Registered Nurses can delegate the task of undertaking observations to competent staff (including students)". This meant we could not be assured processes were being followed and staff managed the deterioration of patients in the community. However, staff within unplanned care were routinely using CEWS.
- Within the podiatry service there were 1,400 patients county-wide waiting for routine treatment on the waiting list. We enquired how they assessed the risk to patients on the waiting list. Every patient referred to podiatry receives a letter which details how to recognise deterioration in their condition and how to contact the service. Staff confirmed they were dependent on the patient phoning to say their condition had deteriorated. This meant the service did not have systems or processes in place to manage the risk to patients on the waiting list.
- Within the phlebotomy services we did not see any guidance for staff who may acquire a needle stick injury; there was no risk assessment in place to support staff. However, we saw that sharps disposal containers were available. A sharps container is a rigid puncture and leak resistant box designed to hold used sharps safely during collection, disposal and destruction.
- Staff within the phlebotomy service informed us they did not take blood from any pregnant female including taking bloods for the glucose tolerance test (GTT). The GTT measures the body's ability to use a type of sugar, called glucose that is the body's main source of energy. A GTT can be used to diagnose prediabetes and diabetes. However, the service did not have any procedures or checklists in place to ensure that all females seen were asked if there was a possibility they may be pregnant. Staff we spoke with said they relied on the GP requesting the blood tests to ensure all necessary checks had been completed.
- Staff within the multiple sclerosis team confirmed that they completed the initial assessment for their patients. We saw evidence of a system in place to conduct a follow up assessment to review how patients were coping with their symptoms.
- Patients who were at high risk of developing serious problems with their feet were provided with a booklet called "how to spot a foot attack." The booklet provided

a check list of areas to review, how to prevent future problems and whom to contact with any concerns. We observed a patient being given the booklet during a consultation.

- The community services used the Waterlow score. The Waterlow score gives an estimated risk for the development of a pressure sore in a patient. Patients identified at risk had care plans and frequent monitoring by staff to reduce the risk of harm. We saw the completion of accurate Waterlow scores was included in bank and agency staff induction sheet.
- The intermediate care team had robust arrangements in place to ensure all patients were discussed at a handover once they had been seen. This was done by telephoning the intermediate care team live handover team.

Staffing levels and caseload

- There were three risks on the risk register relating to staffing levels across community health services for adults. They included ongoing pressures on staffing levels due to sickness, vacancies and maternity leave, difficulties recruiting band 7 nursing staff and advance nurse practitioners, and electronic rostering challenges across the intermediate care team (ICT) and evening district nursing teams.
- The trust data showed a vacancy rate across the community services of 27% for qualified nurses and 9% for nursing assistants.
- The trust utilised the safer care nursing tool for their staffing levels' acuity and dependency reviews along with National Institute for Health and Care Excellence guidelines and professional judgement.
- Staff we spoke with said the electronic rostering system used to allocate shifts to staff members did not always produce the required robust staffing levels for the ICT and evening district nursing teams therefore senior staff often had to manually alter staff rotas.
- The staff team within the podiatry service had a full complement. Senior staff confirmed they used bank staff to cover sickness and holidays.
- We saw evidence that showed additional staff were used when the needs of patients required this. The rotas we saw showed that any identified gap had been covered by the use of agency or bank staff. Senior staff confirmed they aimed to use the same agency nurses where possible to provide continuity to both patients and the staff team. Staff rotas showed that there were sufficient levels of staff on duty to meet the needs of the patients in the service.
- Senior staff within the community district nursing teams confirmed they had high bank and agency use. For example, we saw the average percentage of shifts filled with agency staff across community health services for adults from October 2015 to September 2016 was 65%. This equated to 1,905 total shifts filled by bank staff and 79 shifts filled by agency staff.
- All staff we spoke with confirmed their caseloads were flexible and manageable. Senior staff told us that staff's caseloads were regularly reviewed and incorporated into their supervision.
- The podiatry surgical services did not have access to an anaesthetist and should one be required they would "blue light" the patient to A&E. This was also highlighted as a concern during our previous inspection in February 2015. This meant there continued to be a risk to patients' care and welfare. The trust informed us that the service did not require the presence of an anaesthetist because of the surgical procedures carried out and any clinical emergency would be dealt with appropriately and emergency services accessed.
- The total caseload for the tuberculosis service, as outlined in the tuberculosis in Northamptonshire annual report 2015 was 47, of which 21 were female and 26 male. The service also had five children under the age of 20 diagnosed in 2015. Two small children diagnosed aged six months to three years and three teenagers.
- The tuberculosis nursing service was made up of 1.8 whole time equivalent specialist nurses, supported by a shared administrator. The tuberculosis service met national recommendations of a ratio of specialist nurses to tuberculosis cases of 1:4.

Managing anticipated risks

- We reviewed the lone working procedures. These were adapted by the individual community nursing teams. Staff told us how the arrangements worked for their teams. This included reporting by phone or text

message when they arrived at and left a patient's home when working out of hours. We saw the lone working arrangements for unplanned care. Staff phoned into the office after every visit. Staff in the base office used the electronic system to check the whereabouts of staff and would contact them if they had not telephoned in after a visit.

- Staff confirmed they would work in pairs if a risk was identified regarding the patient or location.
- Community nursing teams had contingency plans for adverse weather conditions. This included the availability of suitable vehicles for driving in for example, snowy conditions. Staff described the actions should a patient not answer the door. They gave a good account of the actions they would take. However, we did not find written protocol for staff to follow to support their actions.
- There were appropriate arrangements in place across unplanned care services in the event of a power cut or the electronic systems and phones went down. During our inspection, there was a power cut at Highfield Clinical Care Centre, which meant that ICT staff in the live handover contact centre were unable to receive calls and access systems. Staff informed their colleagues working from another contact centre that took all incoming calls until staff had travelled to another hub office to resume their duties.

Major incident awareness and training

- Staff described how to respond to a major incident by following the organisational response.
- Staff said that they did not undertake any training in major incident awareness

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

Overall, we rated the service as good for effective because:

- Community services demonstrated that care was provided in accordance with evidence based guidance, standards, best practice and legislation. However, we saw that some policies were out of date, for example the pressure ulcer policy was last reviewed in 2014.
- Pathways were used extensively to ensure best practice in the management of patient care.
- Patients' pain was appropriately managed as was the nutrition and hydration of patients.
- We observed effective multidisciplinary working to provide co-ordinated patients care.
- The service reported good performance in a number of national audits such as podiatric surgery.
- The service scored highly in the trusts "I want great care" questionnaires with 94% of patients saying they would recommend the service to their family and friends.
- Senior staff oversaw staff competencies which included the administration of insulin and leg ulcer management which were based on NICE guidance.
- Staff received either one-to-one or team supervision during their monthly team meetings. Ninety two per cent of staff had received their annual appraisal.
- The intermediate care team (ICT) facilitated early discharge from hospital where a health monitoring or rehabilitation need had been identified.

However:

- The phlebotomy service did not have a standard operating procedure (SOP) to provide staff with step-by-step instructions to support staff in carrying out their daily routines. During our unannounced however, we saw the service had implemented a SOP to support staff in their role.
- The phlebotomy service did not have systems and processes in place in accordance with the service level agreement (SLA) requirement which stated that all interventions are "evidence based and audited regularly in respect of quality and effectiveness." During our unannounced visit we saw the trust had implemented a checking record for all patients visiting the service to measure these outcomes.
- The trust audit plan did not include all community health services audits.
- The trust used an electronic recording system. However, the speech and language service did not have access to this system which meant they may not have all the relevant information to support the patient in their care needs.
- Although staff knew of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards processes, the training records showed poor compliance (70%) which was below the trust's training target of 90%. This meant we could not be assured staff that staff had the relevant skills to refer patients appropriately.

Evidence based care and treatment

- Evidence based guidance, standards, best practice and legislation ensured the planning and delivery of patients' care.
- The phlebotomy service did not have a SOP. In accordance with the Word Health Organisation (WHO) Guidelines on Drawing Blood: Best Practices in Phlebotomy a SOP is required for each step or procedure. This should be written and be readily available to staff. During our unannounced visit on 9th February 2017, the service manager informed us they had implemented a SOP which we saw was available on the trust's intranet service.
- Most policies were relevant and accessible by staff via the trust's intranet system. This included guidance, such as National Institute for Health and Clinical Excellence (NICE). However, we saw that some policies were out of date, for example the pressure ulcer policy was last reviewed in 2014. This was brought to the attention of senior staff.

Good

Are services effective?

- The community speech and language therapy services for patients who were undergoing rehabilitation following a stroke were delivered in line with the NICE guidance (CG162): Stroke rehabilitation in adults (2013). This included providing swallowing and direct impairment therapy for patients with dysphagia, teaching patients other methods of communication such as gestures and the use of communication props and supporting the patient to access information that enables decision making.
- The podiatry adult surgical service for Northamptonshire were commissioned for one surgical list and three follow up clinics per week at both Danetre Hospital and Battle House. We saw their procedures for day cases were in line with the NICE guidance the Royal College of Podiatry which ensured that patients were:
  - Fit to undergo surgery
  - Had home circumstances which were safe for them to return to on the same day
  - Physically able and willing to comply with post-operative guidance which included individualised exercise.
- The podiatry service's standard operating procedures provided staff with guidance on the surgical pathway which included; referral and appointment management, do not resuscitate pathway, and the discharge process.
- The multiple sclerosis (MS) team complied with NHS England's guidance for Disease Modifying Therapies for Patients with MS May 2014. Disease modifying drugs are a group of treatments for patients with relapsing MS. They reduce the number of relapses a patient might experience as well as reducing the severity of any relapses they have.
- The MS team used the expanded disability status scale (EDSS) as a method of quantifying disability in MS and monitoring changes in the level of disability over time. The EDSS scale ranges from zero to 10 in 0.5 increments that represent higher levels of disability. Scoring was based on evidence established by the dedicated neurologist assigned to the MS team.
- The tuberculosis (TB) service adhered to the NICE (NG33) 2016 and NHS England's strategy for 2015 to 2020 which looked at 10 key areas such as improving access to services and ensuring early diagnosis.

Pain relief

- Staff we spoke with said they used a tool on the electronic records system to assess pain although we did not see this in practice during our inspection.
- Patient's pain was identified on the initial assessment and district nurses confirmed they liaised with the patient's local GP regarding their pain management.
- When patients attended the pain management clinic we observed good interaction between the patient and staff which included psychologists, occupational therapists and the chronic pain management team.

Nutrition and hydration

- The community services used the Malnutrition Universal Screening Tool (MUST) for screening patients who may be at risk of malnutrition. MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition (under nutrition) or obese. During our inspection we saw evidence of MUSTs documented in patient records where relevant and mitigating actions were taken when appropriate.
- Senior staff confirmed they conducted a MUST audit each month.

Patient outcomes

- Information about the outcomes of patients care and treatment were collected and monitored. The trust had an audit plan however, not all community health services for adult audits were included on the trust audit plan.
- The service level agreement (SLA) with the local commissioners for the phlebotomy service stated that the provider should ensure that all interventions are evidence based and are audited regularly in respect of quality and effectiveness. However, staff informed us they did not register the patients attending the service. This contravened the guidance set out in the SLA. This meant there were no systems or processes in place to manage the patient's receiving care and treatment from the service, and quality and patient feedback could not be measured.
- Staff within the phlebotomy service were not aware of the SOPIn accordance with the WHO Guidelines on Drawing Blood: Best Practices in Phlebotomy, a SOP is

required for each step or procedure. During our unannounced inspection, we found that there was a SOP for phlebotomy and this was readily available to staff.

- Patients were asked to complete "I want great care" questionnaires so the service could assess and monitor the quality of the service and the outcomes of the treatment provided. We saw on display the score result within the Brackley community team which had achieved an average score of 4.54 (based on 2,359 reviews) which was just below the trust target of five for dignity and respect of patients, patient involvement, information provided to the patient and attitude of staff, 94% of patients said they would recommended the service to their family and friends. Staff confirmed they received feedback from the analysis of the questionnaire during team meetings.
- A retrospective audit of incidence of blockage of enteral feeding tubes was completed in October 2015. The key findings identified were that size nine tubes were more prone to blockage. The audit team shared the data with endoscopy teams at two local hospitals where tube were inserted and discussions were held around the appropriateness of using larger tubes in the absence of any other issues.
- Speech and language therapists used a therapy outcome measure form to monitor a patient's progression by scoring them between one and four for their level of impairment, activity, participation, well-being and distress.
- The podiatry service at Battle House conformed to the Podiatric Audit of Surgical and Clinical Outcome Measures. We saw the results of the last audit from June 2016 to January 2017 based on 141 treatments. The report did not highlight any issues or concerns. None of the patients said their condition had deteriorated and got a little worse after their procedure.
- The podiatry surgery team conducted clinical trials in 2014. Patient and clinical outcomes were captured and 95% of patients said their foot was better at six months after surgery. Staff within the podiatry service confirmed that as a result of the trial they continued to provide this service to patients.
- The podiatric surgery service conducted an audit of advanced diagnostic imaging requests. We saw the results for October 2015. This was based on 283 referrals. The results were fed back to the podiatric surgery team and the radiology department. A further audit was to be repeated in two years' time.
- The Public Health England standard set by the chief medical officer's action plan for tuberculosis is that completeness of treatment outcome is reported in 95% of cases and that 85% of patients complete their treatment successfully. For Northamptonshire the successful completion rate was 82%. For example, we saw that of the 44 cases 82% completed their 12 month treatment against a national figure of 85%. Also, 9% (four patients) had died against the national figure of 5%.
- Staff within the multiple sclerosis team confirmed they were looking at ways of capturing patient's outcomes but did not have these at the time of our inspection.

Competent staff

- Senior staff oversaw staff competencies which included for example; the administration of insulin, leg ulcer management, health promotion, and the use of syringe drivers. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin. Competencies were based on best practice guidelines such as NICE.
- Staff confirmed they received supervision during their monthly meetings. These were undertaken as group supervision. Staff confirmed they were also given the opportunity to have one-to-one meetings with their manager.
- All staff we spoke with told us they had received an appraisal with the exception of a new member of staff. Overall, data showed that 92% of staff across community health services for adults had received an appraisal. Staff said their learning needs were identified during their appraisals.
- We saw systems in place for nursing staff requiring re-validation to be supported. The records seen showed that for example, 100% of the East Northamptonshire nursing team had achieved their revalidation.
- All new staff attended a trust two day induction programme that covered topics such as the trust values and mandatory training.

Good

Are services effective?

- All bank and agency staff completed a local induction sheet to ensure they became familiar with the patients, the surroundings and their role and expectations. Areas covered included, understanding of job role, location of trust policies such as resuscitation, fire safety and moving and handling and pressure area standards.
- Speech and language therapists had access to and were encouraged to undertake specialist training relevant to their role. For example, some staff were booked on to a course in March 2017 where they would be taught voice and speech treatment techniques for adults with motor speech disorders and Parkinson's disease.
- The trust had an ongoing recruitment programme. Where possible, agency staff were block booked to ensure continuity. Rotas were also amended where possible to ensure a suitable skill mix was present on each shift.
- Staff within the diabetic podiatry service had their competencies assessed in line with the Podiatry Integrated Career and Competency Framework for Diabetes Foot Care. The competency framework ensured that patients with diabetes had their feet cared for by healthcare professionals with the appropriate skills.
- The records seen within the podiatry service showed they had achieved 100% at the time of our inspection in their mandatory training which included; immediate life support, anaphylaxis (an acute allergic reaction, health and safety, Mental Capacity Act 2005 (MCA) and safeguarding level 2.
- The Northamptonshire diabetes multi-disciplinary team had undertaken study days with a local ambulance service on diabetes management and were involved in a research study titled "The ambulance hypo study". Staff also completed additional competencies relevant to their role such as venepuncture, the use of compression bandages and delirium training.

Multi-disciplinary working and coordinated care pathways

- All necessary staff, including those in different teams and services, assessed, planned and implemented patient care.
- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices that delivered coordinated care to patients. We observed good interaction between the intermediate care team (ICT) and a specialist community-based multidisciplinary team, which included for example, consultants, nurses, occupational therapists, physiotherapists, psychiatric nurses, rehabilitation technician and assistants and the community nursing teams. When required, the ICT also accessed other trust services such as podiatry, dietetics and specialist nurses.
- We saw good interaction within the pain clinic which included psychologists, physiotherapists, occupational therapists and the chronic pain management team.
- District nurses could access the diabetic link nurse when required.
- A single point of access (SPOA) service had been developed and was operating in the south of the county until the service is rolled out throughout the north of the county. The SPOA service was a new initiative and aimed to provide the right care, from the right practitioner at the right time.
- Specialist nurses were available to provide support when required. Staff said they worked within a collaborative team. Community nurses described a close working relationship with the tissue viability nurse and community therapists.
- Community nursing teams and the intermediate care team worked together to provide care and treatment for patients in their own home. Staff confirmed they worked together to ensure all visits were co-ordinated to prevent anxiety and confusion to patients.
- The Northamptonshire diabetes multidisciplinary team (NDMT) was an integrated countywide specialist diabetes service, supporting care closer to home for patients with type 1 and 2 diabetes. The specialist team included nurses, dietitians, podiatrists and wellbeing workers, assisted by a team of support workers and supported clinically by a diabetologist. The NDMT had developed a prevention programme for people who were at risk of developing type 2 diabetes. The trust told us they had also developed the "Me and My Diabetes" programme which was designed for people living with a learning disability.

- Musculoskeletal physiotherapists provided assessment, diagnosis and treatment for patients with musculoskeletal pain and dysfunction such as pain, stiffness, muscle weakness, instability and reduced mobility of joints and muscles. The service was a multi-disciplinary therapist team including physiotherapists, occupational therapists and extended scope practitioners (ESPs) over 13 sites countywide. Treatment provided included; physiotherapy classes, exercise therapy and mobilisation and manipulation techniques.

Referral, transfer, discharge and transition

- Community services used the 18 week referral to treatment time as a target. Patients using the services could either by referred by their GP or consultant or self-refer.
- The patient contact centre received and monitored all musculoskeletal, podiatry, therapy and diabetic retinal screening calls. These calls were made through GP referrals, consultant and self-referrals. The manager of the call centre confirmed, and we saw that they were able to monitor the number of patients who were due to exceed the 18 week referral to treatment time.
- The community services had an ICT whose role was to prevent avoidable admissions to hospital by supporting patients within their own homes. They also facilitated early discharge from hospital where a health monitoring or rehabilitation need had been identified. The ICT worked in partnership with other health and social care organisations and if required, referred these patients for further assistance after their stay with ICT. Should the patient's health deteriorate due to illness or trauma, they would be referred back to the service as often as necessary to reduce the need for a hospital admission.
- The ICT provided a crisis intervention service of up to two weeks. This involved the completion of assessments and the treating and monitoring of patients with complex, difficult and reoccurring health care needs. However, staff stated the service was incorrectly used and they were often expected to respond and take referrals of patients who were not in crisis which was both time consuming and not constructive to the patient.
- Staff worked well together to assess and plan ongoing care and treatment in a timely way when people were due to move between teams or services. We observed good team working and effective communication between district nursing teams, the evening district nursing team and the ICT.
- Staff used the electronic records system to communicate with GPs when a patient was discharged from their care. Some staff said they would contact the GP by telephone ahead of discharge to inform them of their decision.
- Speech and language therapists received paper referrals from GPs because they did not have access to the generic electronic system used by GPs and community nursing staff. This meant speech and language therapists could not communicate with GPs electronically. Staff we spoke with said they wrote to GPs and sent the letter by post once they had seen a patient. Staff said referrals they made to other services were sometimes duplicated because they had no means of knowing if a referral had already been made.
- Advanced nurse practitioners (ANP) provided a rapid response to patient's needs and completed a comprehensive specialist assessment from which they formulated a personalised plan. For short stay patients in hospital the ANP would evaluate whether patient's required additional support at home to prevent extended stays in hospital.

Access to information

- All nursing staff carried a portable electronic device when caring for patients in the community which meant they had access to patient records at all times. The portable devices replaced the laptops that staff used previously and were funded as part of the community nursing transformation programme. This meant that staff had full access to clinical records and updated records whilst in the patients' home which thereby reduced the need to return to base. Staff we spoke with said they were able to share resources such as surveys, assessments and support materials with patients and their carers.
- Speech and language therapists did not use the same electronic records system as other staff across the trust. They completed paper-based forms when they visited patients and updated care records on their individual system when they returned to their base. Staff we spoke with said they were not always aware of patients'

medical histories or social and living circumstances because they did not have access to the electronic system used by other community staff. Staff said they were not aware of any plans in place to give them access to the generic system used by their colleagues. This meant that we could not be assured that therapists had relevant information to support the needs of patients in the community.

- Staff had access to relevant files within their departments. For example, within the podiatry unit we saw information about Control of Substances Hazardous to Health with built in risk assessments.
- All staff could access best practice guidance and trust policies which were stored on the trusts internal intranet.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with understood how consent and decision supported patients to make decisions as required by legislation and guidance, including the Mental Capacity Act 2005 (MCA).
- Staff confirmed familiarity with the consent policy and showed us how they could access the information on the trust's intranet.
- The audit results for January 2017 showed an overall positive improvement in both staff attendance at MCA training and the current level of knowledge and awareness that staff had relating to MCA and Deprivation of Liberty Safeguards (DoLS). There was still further improvement required and the focus on MCA training would continue.
- MCA training and the DoLS training are combined non-mandatory training sessions at the trust. Those eligible are required to attend an update once every three years. The trust had not set a compliance target. The training record for the community service was 70% which was below the trust reported training target rate of 90%.
- The trust provided information around the number of DoLS applications made (64) and the number of applications received (61). We found none of these related to the community services.
- Staff demonstrated an awareness of the MCA and DoLS procedures. They were able to describe how they would support a patient that may lack capacity to make decisions. Staff confirmed they had received training and guidance regarding the MCA and DoLS. We saw on display information regarding safeguarding and details of whom to contact.
- Patient's electronic records had a copy of the patient's consent to care and treatment and the sharing of information with others for example, their GP.

Good

Are services caring?

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

Summary

We rated the service as good for caring because:

- Patients were treated with respect and kindness, and their privacy and dignity was protected.
- Patients understood their care and were involved in making decisions about their care.
- Staff were supportive of patient's relatives and carers and involved them in patients care.
- Staff understood the impact of a patient's condition and care and how it may affect their wellbeing.

Compassionate care

- Staff understood and respected patient's personal, cultural and social needs. Community nursing staff we spoke with at Danetre Hospital said they would rearrange their day and change the time of a patients visit should a family member be taking them grocery shopping. Patients we spoke with said staff were respectful when they entered a patient's home. One patient said the nursing staff would wait for the patient to finish eating if they entered at meal times, no matter how busy they were.
- Patients we spoke with told us staff listened to them and were supportive. One patient said "they are always very professional but I consider them my friend".
- Staff felt they were able to raise concerns about challenging patients or relatives and would report abusive behaviour or attitudes to their line manager and at handovers. Staff we spoke with said they would work in pairs if they had concerns about a patient or their relatives.
- Patients we spoke with said their privacy and dignity was respected within their homes. Staff we spoke with said they asked for permission to close doors if relatives were inside a patient's home, and to close curtains and blinds their home was overlooked or could be viewed by passers-by.
- In the physiotherapy department at Danetre Hospital, patients were treated in curtained cubicles which meant there was a risk that conversations could be overheard. However, in addition to the curtained cubicles, there were also individual treatment rooms within the physiotherapy department that staff often used.
- We did not observe any care being given to patients who reported they were in pain during our inspection. However, we observed nurses discussing patients' pain during dressing changes at handover so that other staff were aware when they next visited.
- We observed staff asking patients if they were comfortable and if they needed anything before leaving a patients home.

Understanding and involvement of patients and those close to them

- All patients we spoke with said their care and treatment was explained in a way they could understand. However, not all patients were aware they had a care plan and what it contained.
- All patients we spoke with knew how often community nursing teams would visit them and roughly how long they were expected to be under their care where care wasn't required long term.
- Staff were able to describe patients who required additional support to help them understand their care and treatment. For example, staff made arrangements for language interpreters for patients who did not speak English.
- Staff ensured that patients and their relatives were able to find further information by signposting them to specialist services and providing information leaflets. Patients and their relatives we spoke with said they felt comfortable asking questions and often did. All patients we spoke with said they knew how to contact staff should they need to.
- Patients were involved in decision-making about their care and treatment. One patient we spoke with said a member of staff explained the benefits of a different type of stocking however the patient declined and the staff member was very understanding.

Good

Are services caring?

- Four patients told us staff often asked the patients relatives and carers how they were feeling and if they required any advice or support.

Emotional support

- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them both emotionally and socially.
- Patients reported staff always introduced themselves and were very respectful and showed kindness.
- We observed how staff appeared to understand and show how they supported the emotional and mental health needs of patients and said they were able to access specialist support if necessary.
- We observed community nurses provided emotional support to a patient on the phone who was distressed. They spoke calmly and with respect whilst respecting the person's dignity.
- Staff knew how to contact spiritual advisors to meet the spiritual needs of patients and their families.
- During live handovers and face-to-face handovers, community nurses discussed the impact that a patient's condition and treatment would have on the patient and their relative's wellbeing.

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 the service as good for responsive because:

- Services were planned and delivered to meet the needs of patients and those of the local health economy.
- Patients were seen for an initial assessment in a timely manner once they had been referred.
- The intermediate care team (ICT) worked with local hospitals to reduce admissions and facilitate early discharges.
- The tuberculosis (TB) service provided a screening service for patients suspected of having TB.
- Arrangements were in place to enable patients to access translators and leaflets in different languages for patients who did not speak English.
- Female chaperones were available for appointments when required.
- Services accommodated patients with complex needs. For example, appointments were extended for patients living with dementia or a learning disability.
- Services had been designed in a way that ensured the most urgent patients were seen as a priority.
- Patients knew how to make a complaint and information about making complaints was displayed across services. Staff knew how to manage and resolve complaints.

However:

- Patients were not given a specific time of when they would be visited.
- Formal complaints were not always responded to within a timely manner.

Planning and delivering services which meet people's needs

- Community nursing services had been designed to meet the needs of the local population. Community nursing teams covered different areas throughout the county and cared for patients with long term needs.
- The ICT works with local hospitals to reduce admissions and facilitate early discharges from hospital.
- Evening district nursing teams delivered a service to patients from 6pm to 1am to meet the needs of patients in their homes out of hours.
- The back pain service focussed on improving the quality of life for patients in continuing pain, a selected group of eight to 12 back pain sufferers met for three hours per week for nine weeks. This was followed up by a three or six month follow up. The programme covered areas such as; relaxation and mindfulness techniques, managing sleep problems and developing practical coping strategies.
- Staff in the back pain clinic said they facilitated patients to achieve individual goals to manage their back pain by using specific, measurable, achievable, realistic and timely objectives.
- Staff said patient involvement was essential to their well-being and they were encouraged to discuss their back pain in groups and share experience and well as individual one-to-one reviews. During a back pain clinic we observed patients being given handouts to manage their pain. We saw all participants agreed they understood what had been imparted to them. One patient commented that is was a "great pain group to attend" and another said it helped them to "keep going and carrying on with what they were doing."
- The Northamptonshire diabetes multi-disciplinary team were setting up insulin groups by using a conversation maps programme. The conversation map programme is a patient-centred, innovative tool for diabetes education.
- The Northamptonshire diabetes multi-disciplinary team provided different programmes for patients with diabetes. The trained educators were there to support the patient to gain the knowledge and skills to manage their diabetes. Participants were invited to bring along their family, friends or carer. Each patient attending the programme was given a booklet which provided plans and resources to support their personal action plan. The

aim of the course was to ensure patients led a normal a life as possible while controlling their blood glucose levels and reducing the risk of long-term diabetes complications.

- The Northamptonshire diabetes multi-disciplinary team said they had recognised that they needed to provide more public engagement with more diverse groups. They were looking at providing a black and minority ethnic package, which included Ramadan study days with a view of training community leaders on diabetes and the impact of fasting.
- The tuberculosis (TB) service offered two weekly nurse-led clinics for TB screening. From January 2016 to December 2016, 400 patients were invited or referred for screening in one of the two clinics. Patients are able to self-refer to these clinics or be seen at the request of primary and secondary care practitioners, other non-health partners and TB services from other parts of the country.
- The TB nurses visited patients diagnosed with in order to support and educate them about their illness and treatment. Places of residence included care homes and prisons. Contact tracing is carried out and appropriate screening arranged. The patient is supported throughout the course of their treatment, usually six months, in order to encourage and monitor compliance, detect problems early and avoid hospital admission.

Equality and diversity

- The Workforce Race Equality Standard (WRES) findings from the NHS staff survey 2015 found the trust performed worse than the national average with 16% of black and minority ethnic (BME) staff at the trust experiencing discrimination at work compared to 13% nationally. The trust also performed worse than the national average of 78% with 74% of BME staff at the trust believing that the organisation provides equal opportunities for career progression or promotion. The trust scored slightly better than the national average with 29% of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months compared to 30% nationally and also better than the national average with 20% of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months compared to 23% nationally.
- Senior staff were aware of the findings of the WRES and confirmed they had systems to manage any identified concerns.
- The TB service identified patients who may feel ostracised and stigmatised due to their illness. TB nurses said they visited patients, within reason, at a place and time of the patient's choice. The nurses acted as patient advocates where appropriate and often liaised between the patient and other agencies. Where it was difficult for patients to access clinics, arrangements would be made to visit their workplace or social clubs. This meant that the social, cultural and practical needs of patients were accommodated as far as possible.
- Staff confirmed that female chaperones and hospital transport for appointments were available when required.

Meeting the needs of people in vulnerable circumstances

- The trust attended a Multi-agency Risk Assessment Conference (MARAC) that took place six times per month. The aim of the MARAC meetings was for a range of agencies such as the police, healthcare services and child protection to share information and increase the safety and wellbeing of domestic abuse victims and their children by developing and implementing a risk management plan that provides professional support to victims.
- Services were planned, delivered and coordinated to take account of patients with complex needs, for example, those living with dementia or those with a learning disability. The service understood the needs of vulnerable patients and what they required to do to support patients.

Access to the right care at the right time

- We requested data from the trust to identify how long patients waited from their initial assessment to treatment. The trust stated they were "unable to distinguish onset of treatment from assessment using the current systems". The trust did not provide any targets for days from initial assessment to onset of treatment for any of the community health services for adults.
- The average number of weeks from referral to treatment (RTT) varied between services. For example, from

October 2015 to December 2016 the podiatric surgery service had the highest average RTT time (21 weeks) followed by the diabetic foot and high risk podiatry service (nine weeks). The average RTT for adult dietetics was seven weeks and four weeks for speech and language therapy services.

- The number of days to from referral to initial assessment varied between services. For example, the diabetic foot and high risk podiatry service had the highest average days from referral to initial assessment (13 days) followed by the community therapy rehabilitation team (10 days). However, we saw patients referred to the evening district nursing team and the ICT were seen within 24 hours of being referred which meant that care was prioritised for those patients with the most urgent needs.
- The district nursing team said the new single point of access service was causing some anomalies due to the staff being unaware of local areas which made it difficult to transfer to the appropriate team when busy. This meant there may be occasions that patients could be directed to the wrong service and cause delays in their care and treatment.
- Patients we spoke with said they were not given an exact time of when a member of the community nursing team were visiting them.
- The patient waiting list for physiotherapy was identified as a concern during the last inspection with patients waiting up to eight months. However, we saw this had been addressed and the waiting time at the time of our inspection was averaging 13 weeks. The physiotherapy services had currently 1,127 patients on the waiting list, of which 955 were in Northampton, 46 in the north of Northamptonshire and 126 in the Daventry and south of Northamptonshire area. Senior staff at the patient contact centre confirmed they were able to monitor potential breaches and provide patients with alternative venues for their treatment.
- The multiple sclerosis service did not have a waiting list and saw most patients within six weeks of referral.
- The TB service had a rapid referral pathway and two weekly open access TB screening clinics, one in Kettering and on in Northampton to ensure that, once TB is suspected, patients are seen by a TB specialist within the two weeks as suggested by the Department of Health document "Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high-quality services in England." The tuberculosis service averaged 86 days (12 weeks) for diagnosis from the initial referral.
- Within the podiatry service there were 1,400 patients county-wide waiting for routine treatment on the waiting list.
- The percentage of patients who did not attend (DNA) their appointment and gave no advance warning differed between services. The diabetic foot and high risk podiatry service had the highest DNA rates across community services for adults. From October 2015 to September 2016, 22% of patients did not attend, followed by the musculoskeletal hand therapy service (21%). Services which had the lowest DNA rates were the specialist heart failure nursing service (0%) and adult dietetics (0.1%).

Learning from complaints and concerns

- The trust's Chief Executive has overall responsibility for complaints but would delegate responsibility to other designated executive directors as appropriate.
- The foundation trust board of directors receive complaints and Patient Advice and Liaison Service (PALS) reports quarterly throughout the year to ensure that complainants received quality responses with answers that are effective, empathetic and clear. Every quarter the complaints review committee meet to oversee the management of complaints and ensuring the quality of responses, that all complaints are handled effectively and fairly without discrimination and that learning outcomes are identified, acted on and embedded and that learning is put into practice.
- Information was displayed across all sites explaining to patients and those close to them how to make a complaint. There were systems in place for complaints to be investigated and responded to.
- Staff we spoke with said they would always try to resolve issues or potential complaints locally. If they were unable to do so, they gave patients the telephone number for the complaints department or referred them to the patient advice and liaison service.

Good

Are services responsive to people's needs?

- The two most common theme for complaints received about community health services for adults were 'all aspects of clinical care' and 'staff attitude'. Senior staff were aware of themes from complaints.
- Lessons learnt and complaints were discussed at team meetings and we saw evidence of complaints being shared between localities. For example, the physiotherapy staff at Danetre Hospital had discussed a complaint from a patient that had been seen at Highfield Clinical Care Centre. Staff said they often discussed complaints that occurred in other clinical areas to highlight any potential areas for concern within their own place of work.
- From January to December 2016 the trust received a total of 34 complaints relating to community health services for adults; five of which had been withdrawn by the complainant.
- All complaints were acknowledged within five days of receipt.
- Not all complaints were responded to within a timely manner. The trusts complaints policy states that complaints must be responded to within 25 days. Of the 29 complaints, 18 (62%) were responded to within 25 days. However, 11 (38%) complaints were responded to outside the 25 day response period. The trust told us that all complaints responded to after the 25 day response period had been discussed and agreed with patients.
- Patients we spoke with knew how to make a complaint but said they had never needed to.

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:

- Staff morale was good. Senior nurses were visible to staff and staff said they felt respected and supported by their managers and colleagues.
- Staff were engaged and each service had arrangements in place for team meetings, clinical supervision and competencies.
- Senior managers had addressed risks identified during our inspection and we saw improvements during our unannounced inspection.
- Service leaders were knowledgeable about most quality issues and service priorities.
- Staff were aware of their local risks and knew how to escalate potential risks.
- Staff were aware of local strategies and initiatives that related to their individual services.
- The lone working policy was well embedded and had been adapted by each different service to suit the staff that worked within it.
- Most staff had a clear understanding of their roles and understood what they were accountable for and to whom.

However;

- Not all risks to patients and staff had been identified, assessed, monitored and mitigated until highlighted during our inspection.
- The phlebotomy service was not assessed or monitored. There was a lack of oversight of the service and it had not been delivered in line with the service level agreement with commissioners.
- There was no overarching strategy for planned and unplanned care. Staff had not been involved in the development of the trust strategy and not all staff were aware of the trusts visions and values.

Leadership of this service

- The community health service for adults was divided into planned and unplanned care. Both planned and unplanned care was lead and managed by a head of service respectively.
- Senior staff we spoke with said they generally had the capacity to lead their individual services effectively.
- The trust had developed a leadership programme, which included options for accredited courses. We spoke with two senior nurses who confirmed they were on the programme and enabled them to learn from each other's experience and share ideas on how they should be managing clinical areas.
- Most staff reported that clinical leads within specialities were knowledgeable, visible and easily accessible.
- Staff felt they had good training and development opportunities and found their managers friendly and supportive.

Service vision and strategy

- The trust strategy described what they needed to accomplish to achieve their vision. The trust had objectives aligned to each theme.
- However, the district nurses spoken with across the service said they had not been involved in the planning of the strategy. This meant that communication was not effective and not disseminated to the staff teams.
- Most staff were aware of the vision for the service. Staff said they were unsure what the acronyms of the vision stood for, but most staff gave a good account of the principles behind them. We saw posters on office walls describing the vision.
- There was no clear overarching strategy for planned or unplanned care. Most staff were aware of local strategies, for example, the multi-disciplinary team and specialist nursing strategy.

Good

Are services well-led?

Governance, risk management and quality measurement

- Not all risks had been identified, assessed, monitored and mitigated. For example, managers were not aware of the risks to staff that delivered, and patients who used the phlebotomy service around infection prevention and control and out of date medical consumables. However, infection prevention and control risks highlighted to senior managers had been appropriately managed and mitigated when we carried out an unannounced inspection.
- Another risk that had not been identified within the service was staff delivered services to children within the tuberculosis and physiotherapy service without the appropriate level of safeguarding training.
- Not all systems and processes had been established. For example, there were no records kept of patients seen within the phlebotomy service. During our unannounced inspection, we saw a basic system had been implemented to record details of patients that had had their bloods taken. This was not yet fully embedded however senior managers were able to describe how the system was going to be utilised.
- The phlebotomy service was not delivered in line with the applicable service standards as specified in the service level agreement. For example, interventions were not audited regularly in respect of quality and effectiveness.
- Community nursing teams did not adhere to the trusts protocol to detect deteriorating patients and not all staff were aware of the protocol. Community early warning scores were not routinely being carried out.
- Most staff had a clear understanding of their roles and understood what they were accountable for and to whom with the exception of staff working within the phlebotomy service. Staff were unsupported in their daily role and were unclear of expectations to report incidents and issues. We were told by a senior manager that phlebotomy staff were able to discuss concerns with senior community nursing staff based within the same location however staff were unaware of support available to them.
- There were arrangements in place for recording risks. There was a clear local risk register for adult's services that was reviewed monthly. There were a total of 32 risks on the risk register at the time of our inspection. Five of which were high risk, 13 were moderate risk and five were low risk. Senior staff we spoke with were aware of the risks on the risk register and told us that all risks marked 'significant' were escalated up to the trust's overarching risk register.
- There were governance arrangements in place. Head of services attended monthly directorate meetings where senior managers discussed performance, risk, governance human resources.
- Quality performance reports were circulated to senior managers and we saw evidence of some aspects of performance being discussed at monthly senior meetings for example, audits and incidents.
- The trust told us that not all clinical audits undertaken across community health services for adults were listed on the trusts audit programme. We could not be assured that the trust had an oversight of all audits being carried out in community health services for adults.
- The trust had undertaken mock assessments across the community service. However, although some staff were aware of the assessments none said they had had any input into the outcomes. The trust told us there was an expectation that the assessments were discussed at team meetings however we saw no evidence of this.
- The district nurses were divided into clusters. Senior staff attended cluster meetings which included for example, an overview of serious incidents and staffing levels. Staff confirmed these meetings were valuable and informative.

Culture within this service

- Staff we spoke with said they felt respected and valued by their colleagues and managers. Students we spoke with across all services said they wanted to work at the trust once they had qualified.
- Staff morale was good amongst all services. Staff we spoke with enjoyed working at the trust.

Good

Are services well-led?

- Staff were dedicated to improving the health and wellbeing of patients. Staff told us they were focussed on improving patient's independence in their own homes.
- We observed good collaborative team working across services. We observed staff shared responsibility at handovers to deliver good quality care to patients.
- The lone working policy was well embedded and had been adapted by each different service to suit the staff that worked within it.

Public engagement

- Patients, their relatives and carers views and experiences were gathered and acted upon and helped improved the services delivered. For example, patients were asked to complete "I want great care" questionnaires so the service could assess and monitor the quality of the service. Patients were also invited to attend patient experience groups to share their experiences. Senior managers were actively involved in patients experience groups.

Staff engagement

- Staff we spoke with said they felt able to raise their views and concerns at team meetings.

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 Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** How the regulations were not being met: • The provider did not ensure that there were systems in place to ensure patients were able to access the right care at the right time, and patients' conditions were not deteriorating. • The provider did not ensure that there were processes in place to routinely monitor and assess patient outcomes. • The provider did not ensure that there were robust systems in place to manage environment, cleanliness and equipment. This was a breach of Regulation 12(1), (2)(a), (2)(b), (2)(d), (2)(f) and (2)(h).

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014** **Safeguarding service users from abuse and improper treatment** How the regulations were not being met: • The provider did not ensure that staff received safeguarding training that is relevant, and at a suitable level for their role. This was a breach of Regulation 13 (1) and (2).