Care Quality Commission

Nottinghamshire Healthcare NHS Trust
Community health services for adults
Quality Report

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This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

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

Summary of findings

Ratings

Overall rating for Community Health Services for Adults	Good	🟢
Are Community Health Services for Adults safe?	**Good**	🟢
Are Community Health Services for Adults caring?	**Good**	🟢
Are Community Health Services for Adults effective?	**Good**	🟢
Are Community Health Services for Adults responsive?	**Requires Improvement**	🟠
Are Community Health Services for Adults well-led?	**Good**	🟢

Summary of findings

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Overall summary

The Health Partnerships Division of the trust works closely with primary care services to provide community health services for Nottinghamshire and Bassetlaw. The division is a partnership model, with services in Nottinghamshire provided by County Health Partnerships, and services in Bassetlaw provided by Bassetlaw Health Partnerships. The trust delivers community services to people with long-term conditions. This included the integrated community teams, falls prevention clinics and continence clinics.

The service covers Nottingham City and Nottinghamshire with an estimated population of over 1 million people. There are a number of areas with lower than average levels of deprivation; Nottingham City is ranked 20th out of 326 local authorities. Additionally, 24 out of 32 health indicators are significantly worse than the England average. Services are delivered in people's homes and from over 80 clinics across the city and county. As you would expect from a service of this size and complexity, we found some levels of inconsistency in the provision of care.

There were systems and procedures in place to safeguard vulnerable patients and to identify, assess and manage risks. However, there was no consistent system to give staff feedback or learn from safeguarding investigations.

There were systems and procedures in place to safeguard vulnerable patients and to identify, assess and manage risks. However, We found some inconsistencies in the level of feedback given to staff.

There were arrangements for comprehensive assessment of patients on referral, communication among members of the multi-disciplinary team was effective and supported the planning and delivery of care. The trust was moving to a "paper light" records system, we found there could be potential risks whilst records are held in written format and electronically. Some teams reported inconsistent access to equipment.

We saw many examples of care, compassion and kindness. Patients were involved in making decisions about care and treatment, privacy and dignity was maintained although the physical layout of some clinics made this challenging. Patients were offered emotional support to enhance their care.

Services were planned and delivered around local need. Staff were responsive and the introduction of integrated care pathways was working well. There were systems in place to receive feedback from patients. However patients were not always told how to complain if they were unhappy with the care they received.

Services were well-led. Staff were well informed, felt supported by their managers, and were engaged.

Summary of findings

Background to the service

The Health Partnerships Division of the trust works closely with primary care services to provide community health services for Nottinghamshire and Bassetlaw. The division is a partnership model, with services in Nottinghamshire provided by County Health Partnerships, and services in Bassetlaw provided by Bassetlaw Health Partnerships.

This report focuses on how the trust delivers community services to people with long-term conditions. This included the integrated community teams, falls prevention clinics and continence clinics. Care was also provided for people with diabetes, epilepsy, respiratory conditions, cardiac and pulmonary disease, and neurological conditions such as stroke, motor neurone disease and Huntington's disease. Most services were offered at outpatient clinics or in people's homes. Some beds were available in care homes to help patients' rehabilitation before returning home.

During our inspection; we spoke to over 75 patients and five carers and relatives. We visited a range of integrated community adult service teams and clinics, as well as a care home where the trust used intermediate care beds. We also accompanied district nurses and community matrons on visits to people's homes to talk to patients and their relatives/carers about their experiences.

We interviewed a range of staff across the division. This included managers, qualified nursing staff, community support workers, team leaders, phlebotomists, physiotherapists, occupational therapists and administrative staff. Some interviews were on a one-to-one basis; but we also held group discussions.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector Hospitals (Mental Health and Substance Misuse), CQC

Team Leader: Jenny Wilkes, Interim Head of Inspection, Care Quality Commission

The team included inspectors, inspection managers, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors, which included district nurses, community matrons, tissue viability nurses and Experts by Experience.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health services inspection programme.

How we carried out this inspection

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

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

- Is it well-led?

We visited Nottinghamshire Healthcare NHS Trust community health services for adults on 29, 30 April and 1 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff, including

Summary of findings

nurses, doctors and therapists, and talked to people who use services, their carers and/or families. We also observed how people were cared for and reviewed their care or treatment records

What people who use the provider say

The friends and family test seeks to find out whether patients would recommend a care provider. At the start of 2014, 75.2% of patients said that they would recommend this service to family or friends.

Patients, their carer and/or family were positive about their care and said staff were caring and committed.

Good practice

Mental health nurses and social workers were included in the integrated care teams, this ensured that patients received all-round, seamless care.

Patients aged over 75 years who were discharged from hospital received a follow-up appointment within 48 hours. This ensured that they had the medication they needed, and provided staff with the opportunity to offer advice on how to prevent their readmission to hospital.

The trust reported a reduction of 61% in the occurrence of pressure ulcers in 2013 which was a result of the implementation of a new strategy and awareness campaign.

The organisation had a single point of contact to request community services. This made access to services easier for patients and ensure resources were used effectively

We saw many examples of teams from across the organisation working well together.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- The provider must ensure that there are robust systems in place to ensure patients are informed about the complaints procedure in the community health setting.

Action the provider SHOULD take to improve:

- Ensure that there is consistent practice on reporting of incidents, specifically, ensuring that staff are clear about when to report incidents and that learning is shared across the whole organisation

- Improve planning the discharge of patients and records of patients using intermediate care beds to ensure care is delivered effectively
- Review the arrangements for ordering of equipment for use in patients' homes to ensure there are no unnecessary delays and ensure clinical staff have appropriate access to clinical equipment for monitoring physical health.
- The policy for staff who work on their own should be used consistently and actively monitored to ensure staff are protected.
- Arrangements for the maintenance of privacy and dignity of patients in clinic settings should be reviewed to ensure it is not compromised and privacy is protected.

Nottinghamshire Healthcare NHS Trust

Community health services for adults

Detailed findings from this inspection

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

	Good ●

Are community health services for adults safe?

By safe, we mean that people are protected from abuse

Summary of findings

There were systems and procedures in place to safeguard vulnerable patients and to identify, assess and manage risks. Staff were clear how to report incidents and make safeguarding referrals. The trust had developed a proactive approach to the management of pressure ulcers in the community setting and had seen a positive impact on the numbers reports.

We found some inconsistencies in the level of feedback given to staff following safeguarding investigations and staff felt they would like more feedback on learning from incidents that had happened from across the trust. At the locations we visited we found the lone working policy was not consistently implemented.

Track record on safety

The trust has not reported any 'never events' for the period February 2013 to January 2014. A 'never event' is classified as such because they are so serious they should never happen.

The trust used the NHS Safety Thermometer, which is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Mechanisms were in place to monitor and report safety incidents, including events such as falls, pressure ulcers and medication errors. Staff told us that in the main, they had feedback from these incidents.

Staff told us they reported pressure ulcers in accordance with the organisation's pressure ulcer prevention strategy. This included wound assessment as well as the development and assessment of treatment plans. This meant that patients were kept under review and preventative measures were applied in accordance with these assessments.

In 2013 the trust reported an overall reduction in pressure ulcers of 61% which was reported to have had a positive impact on other services. This was as a result of implementing a new strategy and awareness campaign.

Are community health services for adults safe?

Learning from incidents and improving safety standards

All staff were familiar with the online incident reporting system and gave examples of how they had used this. Some staff we spoke with at one clinic were not clear on the guidance as to what was reportable and there were inconsistent practices between community teams in regards to what should be reported and when. For example, when staff became aware that a patient had not received the required management for a leg ulcer, although the matter was dealt with immediately, such incidents were not broadly considered or reported as 'near miss incidents' or 'incidents'. The trust may like to note that potential under-reporting of such risks could impact on the accuracy of any trend analysis in regards to the quality of service provision and missed opportunities for improvement.

Where it was reported that patients had developed pressure ulcers a root cause analysis investigation was completed to establish if the pressure ulcer was preventable. Staff told us that as a result of the findings of some of these investigations, the on-line risk assessment tool for pressure ulcer risk scoring had been updated, demonstrating that learning from investigations was implemented.

The trust had a range of mechanisms in place to feedback to staff the learning from incidents. This included an imaginatively named newsletter titled 'The Squirrel' (Sharing Information about Quality Incidents Risk Research Patient experience and Learning across Health Partnerships). This included information on incident reporting and safeguarding. Staff told us they mostly received information through managers at team meetings. Some staff at a clinic we visited told us they received feedback on local incident analysis but did not always receive trust wide feedback. This meant that staff may not benefit from incidents and learning in other parts of the organisation.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

The majority of staff we spoke with were aware of the safeguarding policy and were confident about reporting serious incidents and providing information to the community matron or senior manager, if they suspected poor practice which could harm a person. We saw examples where staff had reported safeguarding concerns, relating to incidents such as missed medicines, or concerns about external third parties. Whilst the staff were knowledgeable and effective in reporting safeguarding they told us that they rarely received feedback on how safeguarding concerns were investigated or the outcomes of the findings. This meant opportunities for learning and development from safeguarding concerns was not being optimised.

We found that a range of electronic and paper based records systems were employed across the different localities. Where staff used electronic systems, they reported inconsistent access to IT, particularly when working in community settings. We saw that in one community service it took staff 15 minutes to access the patient's notes. Staff told us this was common. Where a number of healthcare providers were involved in a patient's care there was a risk of communication delay or breakdown as systems were not compatible.

Assessing and monitoring safety and risk

We found evidence of some lone working arrangements were inconsistent. A lone working policy was in place but there were localised procedures as to how staff were protected. For example, at Park House surgery, managers did not have systems in place to confirm whether staff were on duty and that they would undertake all the required visits. Staff told us that where it had been assessed they should not visit a patient alone there, was a warning included on the patient's electronic record to alert them of the assessed risk.

Understanding and management of foreseeable risks

A 'React to Red' campaign was run by the trust which successfully enhanced awareness and understanding of pressure area care and tissue viability. This focused on the identification and management of Grade 1 and 2 pressure ulcers. Staff told us that all pressure ulcers were now reported as incidents as soon as it was identified there was potential breakdown of tissue. This had resulted in a reduction in Grade 3 and 4 pressure ulcers but there was an upward trend reported Category 1 and 2, reflecting progress made and the focus on preventing deterioration.

Staff reported that the improved reporting of early stage pressure ulcers had reduced the incidence of patients developing more severe pressure ulcers. However so far there had been limited impact on the prevention of early stage pressure ulcers.

Are community health services for adults safe?

Good 🟢

The adult community service was available seven days a week but not in the evening or overnight. Most of the 'out of hours' services were not managed by the trust and was delivered by a number of providers. We found that there were communication issues between the service and the different out of hours providers, particularly in relation to feedback from visits and requests for post discharge visits. This was particularly problematic over a weekend. The times that the 'out of hours' service started to operate in the evening varied in different locations. Staff were unclear about the time the 'out of hours' service could undertake visits and this could also impact on the patients care.

Are Community health services for adults effective?

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

Summary of findings

There were arrangements for comprehensive assessment of patients on referral which enabled staff to ensure care was effective and achieved the right outcomes for the patient. Communication among members of the multi-disciplinary team was effective and supported the planning and delivery of care. The team had the right mix of skills to deliver seamless care to patients at the right time. There was good liaison with local GPs.

The trust was moving to a "paper light" records system, which had a number of benefits but whilst the trust was in the process of this we found there could be potential risks whilst records are held in written format and electronically. Some teams reported inconsistent access to equipment. Discharge processes from the intermediate care beds could be tightened up.

Assessment and delivery of care and treatment

Staff confirmed that when a patient referral was received, the urgency that a patient required treatment or support was assessed by a senior staff member. There were arrangements in place to comprehensively assess the patient's care requirements and possible risks by each professional.

Some localities used a combination of paper and electronic records and we saw that some sets of paper and electronic records contained different information, so neither set was completely up to date. For example, although risk assessment records, such as pressure ulcer risk, had been undertaken these were not always available in patients' written records. Some care plans lacked some of the detail required and there were also some occasional gaps for dates and signatures in care records. However, records were generally comprehensive and a reflection of the positive experiences expressed by patients and those close to them.

We found that the transfer to a 'paper light' system, which included more effective use of computerised records, had reduced the amount of paperwork staff needed to complete. Whilst staff regarded this as being positive, this had resulted in potential increased risks. For example staff reported that access to information technology whilst in

the community was problematic, resulting in a delay in paper care records being available. This meant that if other staff, or staff who visited 'out of hours', might not be fully aware of patients' needs. The trust have acknowledged this and have included it within their risk log.

Staff we spoke with during our visits were familiar with how the NICE guidelines related to their area of work. In March 2014 the trust held a conference for staff to promote NICE (National Institute for Health and Clinical Excellence Guidelines). This included presentations and speakers who showcased how NICE guidelines were embedded into everyday practice.

Outcomes for people using services

The care and treatment of patients achieved good outcomes. Patients told us how they received appointments quickly and described to us how the treatments they received had positively improved their conditions.

The trust was developing integrated care teams this philosophy meant patients were placed at the centre of their care and teams which may include community matrons, community nurses, physiotherapists, occupational therapists, mental health support workers and social workers. All community staff worked together well to deliver good quality care.

Discharge planning for patients, using the intermediate care beds, was not very well documented and planned. A range of information was available regarding discharges but this was held in separate documents and there was no co-ordinated approach. We saw that planned discharge dates were not consistently met and there were no records as to what had delayed the planned discharge. We spoke with one patient who was not aware if there was a discharge plan in place for them. This meant patients may not be discharged from the service in an effective and timely manner.

Staff, equipment and facilities

The staff we spoke with confirmed that staffing arrangements usually met the needs of the patients they supported. Managers told us that there had been times

Are Community health services for adults effective?

when it had been difficult to recruit suitable staff and there were occasions when, as a result of this, vacancies were left unfilled. The trust had recognised the need to recruit suitably qualified district nurse team leaders and had recently agreed to fund staff through the specialist practitioner programme on a rolling annual basis. This will help to address some of the issues around recruitment and senior staff support.

Community nurses told us that at times, cover for sick leave, maternity leave and study leave was not always available and the team were stretched, although we found that sufficient staff were available at the time of our inspection.

All new staff had a trust induction and were then able to shadow experienced staff. Staff we spoke with were positive about arrangements to mentor and support both new and more experienced staff and they were positive about training opportunities. They told us there was access to mandatory training and the content was appropriate to their roles and responsibilities.

Some community nursing teams were led by a Band 6 nurse, with a community matron overseeing at least two district nursing teams. We observed that whilst the teams responded to patients' needs, there were occasions where the presence of a more senior nurse would develop the team. For example during handovers we observed that community staff failed to recognise a need to report near misses and did not challenge the management of a safeguarding incident involving another service.

There were new arrangements in place to monitor the timings of staff visits to ensure that that there was sufficient time available to undertake the visits required. Regular audits of some aspects of staff practice had taken place which included infection control and record keeping. Competency assessments were undertaken for healthcare support workers, occupational therapists and physiotherapists. We were told that qualified nurses' practice may be checked as part of an infection control or record keeping audit although this could not be assured. Qualified nurses were unable to confirm that regular review of their practice, which may include peer review, was undertaken. During visits with community nurses, we noted some nurses were not following good practice guidance. These may have been isolated incidents; however the trust may wish to consider more robust supervision and regular review of practice.

In some localities staff told us about difficulties obtaining equipment for patients, such as pressure relieving mattresses. Recent changes in commissioning arrangements with the equipment supplier meant that equipment could only be obtained once the order was confirmed by senior staff. Only they had a required code, which confirmed the order, this was done electronically. The availability of senior staff and access to the electronic system caused delays which may put patients at risk.

There was an inconsistent provision of clinical equipment available to staff for monitoring patients physical condition. In some localities, each nurse had their own set of equipment whilst elsewhere; staff shared a pool of equipment, which was held at the clinics. This meant that if there was concern, there was a delay whilst staff collected the required equipment or requested support from staff that had it available. This could impact on patient's health and wellbeing.

The trust commissioned beds within care homes to provide support for people requiring rehabilitation. Physiotherapists worked as part of the intermediate care team staff and a range of equipment was used to aid patients' rehabilitation. At one care home we saw that parallel bars had recently been re-sited and were fixed to the floor in a room used for storage. The trust may like to note that the parallel bars were near to the wall in a communal area and were not accessible to staff on both sides. This posed a potential risk to staff and patients and did not provide a dignified and respectful service.

Multi-disciplinary working

We saw there were good multi-disciplinary team arrangements in place to provide support and treatment and positive and flexible attitudes of staff towards multi-agency working. Benefits for patients were they received a prompt response and flexible care in a timely way as there was no need for interagency referrals. Staff felt new staffing arrangements had a positive impact on patient care.

Patients had access to teams, with the appropriate levels of skill mix, to ensure safe clinical care from those best trained to meet their individual needs.

There were new working arrangements which included integrated community teams formed of community nurses, community matrons, physiotherapists, occupational therapists, mental health workers and in some areas, social workers.

Are Community health services for adults effective?

In some areas this had resulted in increased numbers of staff sharing office accommodation, which was having an impact. The trust had recognised that additional offices were required but staff told us this was taking time to provide.

We were told that each team had a daily handover to discuss all patients who had been seen or required a visit that day. This meant that staff were kept informed of the needs of patients on the team caseload. In addition, we were told that monthly virtual 'ward rounds' were undertaken by the multi-disciplinary team to ensure there was an effective treatment plan in place for each patient.

We saw there was good liaison with patients' GPs. Staff told us that the new computer system enabled them to 'task' some GP practices which had a compatible computer system. Staff explained that the 'task function' enabled them to request a review of the patient or a request for a prescription. Staff told us that this system had the

advantage of both ensuring that patients received more timely treatment but that it also provided more effective use of staff time. Community nurses spoke positively about their relationship with GPs. We observed one joint visit between a GP and community nurse to review a patient's pain relieving medication. This meant the patient received timely treatment and was kept pain-free and comfortable.

The organisation had a single access point for requests for community services. Staff, patients and their relatives reported positively about this. Staff said it had reduced the number of duplicated referrals which meant more effective use of their time and resources. Patients and relatives told us they found helpful and meant they could contact the service they required more easily. The service had the ability to offer adjacent appointment times for patients, minimising disruption to daily life. Patients and carers liked this aspect of the appointment systems.

Good ●

Are Community health services for adults caring?

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

Summary of findings

Patients, their families and/or carers said that they were treated with kindness and respect, and that they were involved in making decisions about care and treatment. We saw that staff maintained privacy and dignity for patients although the physical layout of some clinics made this challenging.

Patients were confident their confidentiality was maintained and they were given information to improve their knowledge and management of their conditions. We saw robust processes in place to obtain patients consent. Patients were offered emotional support to enhance their care.

Kindness, dignity and respect

Patients and relatives we spoke with said that staff were kind, treated them with respect and met their individual needs. We observed that patients were afforded dignity and empathy by the community teams responsible for the delivery of their care.

We received many positive comments from patients about the staff, this included, "Staff are very caring", "Wonderful and supportive", "Staff are all very kind and cared for my family too", and "Excellent staff, helpful and very caring".

Patients told us they were confident that staff would respect their confidentiality, that they were given choices about their care and that these choices had been respected.

We observed that, wherever possible, staff promoted patients' privacy and dignity. We observed that staff asked people, when they visited them at home, where they would like to have their care or treatment and ensured that, when appropriate, curtains and doors were closed.

Patients' privacy and dignity was protected by staff. The majority of care provided by the trust was in patients' homes so privacy and dignity was assured. Patients we spoke with confirmed to us that staff positively respected their privacy.

Maintaining privacy and dignity in some of the clinic setting was more challenging but to the physical layout of the premises. For example, Staff in the phlebotomy clinic at Park House clinic raised concern that they had to use the treatment room to take blood from two patients at a time. Also, due to the confines of the room, the door was open which meant that people in the waiting area could see in. Staff said there were no facilities if the patient wished to, or needed to, lie down. In these circumstances, staff would have to wait for the other treatment room to be vacated before they could move the patient. Similarly, patients in the leg ulcer clinic at Beeston told us they felt that two patients receiving treatment in the same room did not respect their privacy. The trust confirmed to us after the inspection this was not normal practice and would review the situation. In the physiotherapy department at Mansfield Community Hospital curtained cubicles were used for patients to receive physiotherapy. Conversations between staff and patients could be over-heard. Staff told us that patients could ask to use private treatment rooms but patients told us this was not routinely offered to them and there were no signs on display to indicate this option was available.

Some patients told us they were offered a choice of a male or female staff member but this was not consistently offered in the locations we visited. One patient said they would have preferred to be given a choice of male or female physiotherapist, but this had not been offered.

People using services involvement

Adults with long-term conditions were involved in and central to making decisions about their care and the support needed. Care was person-centred and supported by individualised health care plans. Patients told us they felt able to ask any questions as they had good relationships with the nurses and other professionals delivering their care. We observed that staff checked the patient's understanding of the treatment required. We saw in a physiotherapy clinic at Park House that in addition to explaining problems and treatment, the physiotherapist used a model to explain the problems the person was experiencing. The patient spoke positively about their experience and was confident about undertaking the required exercises.

Patients were consulted about their care but were not always provided with copies of their care plans. Some staff

Are Community health services for adults caring?

told us they printed out copies of care plans and gave them to patients if they wanted one. Other staff were unaware if it was possible to print out copies and said patients were not routinely offered copies of their care plans.

We saw some information packs on specific conditions such as chronic obstructive pulmonary disease. These provided information to people on conditions and the complications that may be experienced. The packs encouraged patients to take some responsibility for health promotion and self-management of their condition. Patients using a range of services told us that staff provided some information and training on how best to manage their conditions. Staff told us that treatments worked better for patients where there was a partnership approach to engage the person in their own treatment programme.

Staff were aware of the importance of gaining consent from patients and knew about the mental capacity act. Staff confirmed their involvement in assessing patients' mental capacity if it was considered their ability to make decisions was possibly impaired. Staff told us the inclusion of mental health nurses in multi-disciplinary teams meant there were staff available to support other staff members' learning about capacity and consent. Patients were confident that they understood their care and told us they felt comfortable with where and who to go to with questions.

Emotional support for care and treatment

Patients and their relatives told us they were supported emotionally, particularly when their condition changed. One relative told us how the community team had "gone the extra mile" to respond to the deterioration of their relative who required end of life care to ensure their condition could be managed at home.

The inclusion of mental health nurses within integrated community adult service teams meant that patients' psychological and mental health needs were taken into account. We saw that assessments and care plans considered patients' views and expectations, demonstrating that people's perceptions and emotions were considered when planning care.

Some therapies and care were offered to patients in group settings. An example of this was the groups run by physiotherapists which were aimed at reducing the number of patient falls. Patients attending these groups told us they enjoyed the social aspect as well as seeing health benefits from attending the group.

Are community health services for adults responsive to people's needs?

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

Summary of findings

Services were planned and delivered around local need. Staff were responsive and assessments were carried out to identify patients' needs. The introduction of integrated care pathways was working well. These helped to ensure that patients received the right care from multi-disciplinary staff who worked flexibly to meet their needs.

There were systems in place to receive feedback from patients. However patients were not always told how to complain if they were unhappy with the care they received.

Planning and delivering services

The trust provides care over a very large geographical area and a number of Clinical Commissioning Groups (CCGs) commissioned the provision of care. This meant there were differences in each locality as to what the trust provided to patients. We saw there were initiatives and services offered to patients in each locality to reflect the needs of the local population. For example, in most localities, 'out of hours' services were delivered by other agencies. In Bassetlaw, the trust offered a range of GP and nurse-led 'out of hours' services via a single point of access referral system for patients. In Mansfield and Sherwood there had been additional commissioning of nursing staff to care for patients with cardiac and pulmonary disease to meet the increased demand in the area.

People we spoke were positive about arrangements for the planning and delivery of their care Staff we spoke with were aware of the healthcare needs of the local population, particularly in mining areas, and the impact this had on patients, such as in chest conditions.

Right care at the right time

Referral pathways were well established and known to all staff. In all teams we saw there was timely triage and discussions held to ensure that patients received the right service to meet their needs. In multi-disciplinary teams the patients' main area of need was established, but this did not necessarily mean that other team members would not provide care or support if it was assessed that the patient would benefit from their specialism. An example of this was a patient with diabetes who may also require some social work or mental support from the integrated care team.

There were few waiting lists for community based adult services and patients received a prompt service. Most referrals were made by GPs and each referral received indicated the urgency of the need which enabled staff to prioritise appointments. Some services, such as the physiotherapy service, had a patient-led appointment system where the person received a letter inviting them to make contact and arrange an appointment for a convenient time.

The ethos of the integrated care teams was to provide care to patients in their own home and prevent admissions to hospital. This service was known as 'hospital at home'. Our observation of practice and discussions with patients and their relatives confirmed that to be the case. For example, the service had a nurse who contacted all patients who were over 75 years, who had been discharged from hospital, to check they had no problems following their discharge. The service employed community nurses who reviewed patients with long-term conditions such as respiratory conditions or coronary heart disease to support the treatment of their conditions whilst avoiding acute admission if possible.

Care pathway

The trust worked with a large number of other providers and the pathways into care were sometimes varied due to the complexities of county borders. Patients and staff told us of two examples where care pathways were not clear and patients experienced some delays in receiving care from the trust as other agencies were not clear on how to refer to appropriate services. Patients were positive regarding the care received from the trust once services had been accessed; however it is a challenge for the trust as it works across many county borders and with a wide range of agencies and this may impact on the patients overall experience.

A risk assessment tool was used within surgeries to identify patients who may benefit from care from the integrated community care teams. The risk assessment tool was scored as a percentage. Staff told us that the threshold at which a patient was referred to the team varied from GP to GP. This could lead to patients not being able to access services consistently.

Are community health services for adults responsive to people's needs?

Learning from concerns and complaints

The majority of patients we spoke with did not know how to make a complaint and they were not made aware of or given a copy of the trust's complaints procedure. A leaflet was available to describe to people how the complaints procedure was managed but this was not being distributed to patients consistently. For example, some patients told us they would approach Social Services if they were unhappy with their care. At Mansfield Community Hospital there were complaints leaflets for Sherwood Forest Trust but not for this trust, even though both trusts provided care at the site. This meant patients were not consistently provided with information on how to make a complaint.

The trust had systems in place to collect patient's feedback to improve and develop services. The trust participated in a NHS Patient Feedback Challenge programme in 2012 and the project was evaluated in 2013. The programme was developed to spread good and innovative practice in using patient feedback to improve healthcare services. The findings of the project have been used to improve the involvement and recording of patient experiences. As part of the improvements a new website was launched to enable patients to post comments, concerns or compliments about their care.

The trust regularly sought information on patients' experiences through its 'Service User and Carer Experience' (SUCE) surveys. The results of surveys were collated on a quarterly basis. Managers and staff we spoke with were aware of the recent results for each service area. Currently the average scoring for the trust's Health Partnership Division for January – March 2014 was that 75.2% of patients would recommend the trust to friends or family.

Are community health services for adults well-led?

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

Summary of findings

Services are well-led. Staff were well informed and knew who the trust board members were, and they were aware of the trust's ethos and vision. Staff felt supported by their managers, and were supported and engaged in developing services.

There were robust governance processes in place for escalating risks to senior managers, however, we found that the learning from these identified risks was not routinely shared with the community teams which could support the development of a the quality of the service.

Vision and strategy

Staff were well informed about the vision and strategy for the organisation. Staff were able to tell us the priorities for the coming year were around patient safety and care delivery and related to working with other relevant organisations. In relation to long term conditions, this meant avoiding unnecessary admissions to hospital. The vision of the organisation was widely understood and shared by the community teams. Staff were able to describe the vision as the '6 Cs' – care, compassion, competence, communication, courage and commitment.

The trust had developed a two-year business plan which was available to staff in all the areas we visited. This promoted the trust's values and vision for the future and celebrated the achievements in 2013/14. The service development plans prioritised the actions to be taken and what the measures of success would be.

There was a dedicated Health Partnership Newsletter which was produced on a monthly basis. This gave feedback to staff on changes, staff surveys results and upcoming events. Information relating to the trust's core objectives and performance targets were visibly displayed in the areas we visited.

Responsible governance

The trust had a clinical governance system in place, which was used to escalate risks to senior management and ensure there was appropriate investigation of issues and learning was shared. We found that learning was not always being shared consistently by teams in the localities below matron level. For example, during a staff focus group, some senior staff appeared unaware of learning from an incident relating to record-keeping which had resulted in some changes. Also a senior manager said that she did not get feedback from safeguarding and this was a concern especially if there were recommendations regarding staff practice.

There was inconsistent practices between community teams in regards to what should be reported as an incident and when. For example, when staff became aware that a patient had not received the required management for a leg ulcer, although the matter was dealt with immediately, such incidents were not broadly considered or reported as 'near miss incidents' or 'incidents'.

Leadership and culture

Senior leaders were visible to staff. All of the staff we spoke with were aware of the trust's Chief Executive and the Chief Operating Executive for the community health partnerships. All staff told us that members of the board had visited their areas of work and in some instances, worked alongside staff to familiarise themselves with their role.

Services at the point of contact were overseen by team managers. Staff we spoke with were positive about management arrangements and said that team managers and community matrons were supportive. Staff said that they felt listened to by their managers.

A number of staff told us they had completed the staff development and leadership programme or were currently enrolled on it. Staff valued the opportunity to develop skills and learn alongside staff from other parts of the organisation.

Engagement

Without exception, all of the patients we spoke with told us they received an excellent service in the clinics they attended and from the district nurses who made home visits. Patients confirmed they had been given questionnaires to complete giving feedback to the trust on the care they had received.

Are community health services for adults well-led?

The staff we spoke with were passionate about the care they offered to patients. Staff informed us that they had been informed about forthcoming changes to the teams. Staff also spoke positively about how senior managers had implemented the changes.

Staff told us they were "proud" of the work they did and considered that they delivered a "first class" service which they would recommend to friends and family.

Development was underway to establish integrated community care teams and we visited teams who were at different stages of being established. We saw that where they were in the early stage of development staff were engaged in the process of development.

The National Community Service Staff Survey conducted in 2013 assessed the level of staff engagement. The response rate from staff had improved from the previous year and the results showed an overall improvement. The Health Partnership division of the trust was rated as being within the top 20% of community trusts.

Performance Improvement

Nottinghamshire Healthcare NHS Trust predominantly provides mental health services and physical healthcare is a smaller division of the trust. Staff from the healthcare partnerships division told us they had reservations about how they would fit into the wider trust when the merger had taken place a few years ago. However, all staff reported there had been improved access to training and they felt the move had been positive.

Staff told us they had access to training, clinical and managerial supervision. Staff new to the organisation received a two-day induction, which included e-learning. Staff were supported in accessing and attending training. This ensured they had the appropriate skills and training to make effective clinical decisions as well as treat patients in a prompt and timely manner. Training data demonstrated a 92% to 100% mandatory training completion rate for staff working within the integrated care teams.

The majority of mandatory training was done through e-learning which is a computer generated way of learning. The staff watch videos or briefings and have to answer questions on a specific subject. Whilst the e-learning included modules on dementia, staff told us there were gaps in their knowledge and understanding of how best to support patients presenting with dementia and would welcome training in this area.

Information technology challenges were widely acknowledged for staff working in the community and we found that plans were in place to address connectivity issues for these staff members. Agency staff did not always have access to up to date electronic records which meant that staff had to support the agency staff to input reports onto the electronic system, impacting on their own time.

We were told that 'lessons learnt' and areas of practice development within the organisation were shared by community matrons and managers. The community matrons and managers would then ensure their teams were aware of required improvements. We discussed with district nurses examples of how practice could be improved. One team told us that a need for improvement had been identified following a root cause analysis investigation. It was evident from the discussion between other team leaders that this requirement for improvement had not been shared with all the other teams. Team leaders also discussed how they had implemented learning from their district nursing course which had ensured more effective practice. Again, we found that other team leaders were not aware of this innovative practice. We concluded that there was insufficient feedback to staff working below the community matron level.

Service managers told us about the 'Commissioning for Quality and Innovation' (CQUIN) targets that they were working towards. These were targets which the trust had set out to improve. Managers were familiar with the targets that had been set and gave us examples of how these improvements had changed practices.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010 **How the regulation was not being met** Suitable arrangements were not in place to ensure that patients were informed about the provider's complaints procedure. Regulation 19(1)(2)(a)