

The Rotherham NHS Foundation Trust

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Community health services for adults

Quality Report

The Rotherham NHS Foundation Trust
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Summary of findings

Locations inspected






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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Staff did not always report patient safety incidents and did not always receive feedback about incident investigations, and there was inconsistent sharing and learning across the service in order to improve practice.

District nursing teams were under-staffed and taking on increasing workloads. Fast response, intermediate care and, community matrons supported the district nursing teams, and we saw that all staff were dedicated to providing a good service for patients. However, staffing shortfalls meant that nurses could not attend mandatory and other training. Although there were governance structures in place to monitor and manage risks associated with district nursing staffing levels, demands on the service had not been addressed.

Arrangements to minimise risks to patients were in place and we saw elements of good practice including clean

clinic areas, good infection prevention and control practice, a good understanding of safeguarding procedures and, the use of independent and community nurse prescribers.

Care was delivered in line with the trust policies and procedures, national guidance and, NICE quality standards and access to care and treatment and, outcomes for people were positive.

People who received care were treated with compassion and respect. We saw staff worked hard to ensure people received a high standard of care. All the patients people we spoke with were consistently positive about the care they received.

During our inspection we met with some dedicated, innovative staff who demonstrated the values of the trust, were passionate about their jobs and, were proud of their work but felt 'ignored' by the acute trust. Staff morale was low and many staff felt de-valued.

Summary of findings

Background to the service

The Rotherham NHS Foundation Trust provided both acute and community based health services to a population of approximately 257,600 people in and around Rotherham. Community health services for adults were provided in the medicine division within the acute trust.

The trust provided a range of community health services for adults from the following sites; Oakwood Community Unit; Breathing Space; Rotherham Community Health Centre; Aston Joint Service Centre; Rotherham Intermediate Care; North Anston Medical Centre; Health Village; The Park Rehabilitation Centre; Rawmarsh Customer Service Centre and; peoples' own homes.

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Chair Thames Valley Clinical Senate

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included two CQC inspection managers, 12 CQC inspectors and a variety of specialists including: consultant surgeon, consultant in respiratory medicine, a consultant paediatrician, consultant intensivist, a GP, a

student nurse, two midwives, two executive director nurses, a governance expert, an occupational therapist, a speech and language therapist, a matron, two community adult specialist nurses, one health visitor, one school nurse, a physiotherapist, a head of children's nursing and a dentist. We were also supported by two experts by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

How we carried out this inspection

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

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

Before our inspection we reviewed a wide range of information about The Rotherham Hospital NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the Clinical Commissioning Group (CCG), NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

We held a listening event in Rotherham on 17 February 2015 where members of the public shared their views and experiences of the trust. Some people also shared their experiences of the trust with us by email and telephone.

The announced inspection Hospital took place between 23-26 February 2015. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas, outpatient's services as well as in the community services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Summary of findings

We carried out an unannounced inspection on 7 March 2015 at Rotherham Hospital. The purpose of our unannounced inspection was to look at the children's ward and the medical assessment unit.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment delivered by the trust.

What people who use the provider say

We spoke with over 40 people who attended our listening event. Some people were very positive about the care they had received at the trust. Other people were less positive about their care.

The NHS Family and Friends (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The trusts performance in all of the NHS Friends and Family tests in January 2015 was largely positive.

- The trust scored higher than the England average of 96% for the inpatient FFT, with 98% of patients recommending the inpatient services provided by the trust. a total of 361 patients responded to this question.
- The trust scored slightly lower (worse) than the England average of 87% for the A&E FFT, with 73% of patients recommending the service. A total of 997 patients responded to this question.
- The trust scored higher (better) than the England average of 96% for the antenatal question in the maternity NHS FFT, with 100% of women recommending this service.
- The trust scored higher (better) than the England average of 97% for the birth question in the maternity NHS FFT, with 99% of women recommending this service.
- The trust scored higher (better) than the England average of 93% for the post natal ward question in the maternity NHS FFT, with 100% of women recommending this service.
- The trust scored higher (better) than the England average of 97% for the post natal care in the community question in the maternity NHS FFT, with 100% of women recommending this service.

From April 2014, the staff NHS Friends and Family Test (SFFT) was introduced to allow staff feedback on NHS services based on recent experiences to be captured.

Staff were asked to respond to two questions. The "care" question asks how likely staff are to recommend the NHS service they work in to friends and family. The "work" question, asks how likely staff would be to recommend the NHS service they work in as a place to work.

The trusts scores in this test were lower (worse) than the England average. Fifty seven per-cent of staff would recommend the trust for care and 43% would recommend as a place to work. The England averages were 77% for the care question and 61% for the work question.

The trust had a total of 29 reviews during 2013-14 on the NHS Choices web site. Fifty nine per cent of these were positive and 41% negative. On the Patient Opinion website there were 133 reviews, of which 70% were positive and 30% negative. In February 2015, the Patient Choices website gave the trust an overall rating of 3.5 stars out of a possible five which meant patients had rated this hospital as they would be "likely to recommend" it.

The CQC Adult Inpatient Survey was carried out between September 2013 and January 2014. A total of 367 patients responded to the survey. The overall score for the trust was about the same as other trusts. There were ten areas of questioning in this survey and nine out of the ten areas were about the same as other trusts, but the questions relating to the hospital and wards scored worse than other hospitals. This was due to the response to the questions relating to food quality, food choice and single sex accommodation.

In the Survey of Women's Experience of Maternity Care (CQC 2013), the trust performed about the same as other trusts in all of the four areas. The survey asked women a number of questions relating to their labour and birth, the staff who cared for them and the care they received in hospital following the birth.

The National Cancer Patient Experience Survey 2012/2013 was designed to monitor national process on cancer

Summary of findings

care. The trust was performing within the top 20% of trusts for 16 of the 34 areas, the middle 60% of trusts for 13 areas and in the bottom 20% of trusts for five areas. The areas where it was performing well were:

- Patients not been given conflicting information
- Privacy when discussing condition/treatment
- Being able to discuss fear
- Treated with respect and dignity
- Given clear information
- Feeling they were given enough care
- Health got better or remained about the same while waiting for treatment
- Seen as soon as necessary
- Given a choice about the types of treatment
- Given the name of the nurse in charge of their care, given information of who to contact post discharge
- GP was given enough information
- Had confidence in the doctors treating them
- Did not feel doctors talked in front of them as if they were not there
- Had confidence in ward nurses
- Saw GP once or twice before being told they had to go to hospital.

The areas they scored in the bottom 20% were:

- Hospital staff told patient they could get free prescriptions
- All staff asked patient what name they preferred to be called
- Staff definitely did everything to control side effects of chemotherapy
- Hospital staff gave information about support groups
- Staff gave complete explanation of what would be done

The patient-led assessment of the care environment (PLACE) programme are self-assessments undertaken by teams of NHS and private/independent healthcare providers and include at least 50% members of the public. They focus on the environment in which care is provided, as well as supporting non-clinical services, such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. The outcomes of the patient led assessments of the care environment for 2014 showed that the trust was rated worse than the England average for all areas.

Areas for improvement

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

Action the provider **MUST** take to improve

- The provider must ensure there are sufficient numbers of suitably qualified and skilled staff to meet the needs of people who uses the services.
- The provider must ensure staff are working in accordance with the Mental Capacity Act Code of Practice (2005).
- The provider must ensure that community health services for adults' staff are able to attend all relevant mandatory training and other essential training as required by the needs of the service.

Action the provider **SHOULD** take to improve

- The provider should strengthen the engagement with community health services for adults' staff, and develop opportunities for effective communication.
- The provider should ensure community staff have access to information relating to people before providing care and treatment.
- The provider should ensure staff are accessing interpreter services where appropriate.
- The provider should support community and district nursing staff to report patient safety incidents appropriately.
- The provider should ensure staff are involved in learning from incidents and good practice is shared across teams and departments.

The Rotherham NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

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

Requires improvement 

Are community health services for adults safe?

By safe, we mean that people are protected from abuse

The safety in community health services for adults required improvement.

There were systems in place to identify patient safety incidents but we were concerned that not all patient safety incidents were raised appropriately or, that appropriate investigations or learning from incidents had taken place. Throughout our inspection we found little evidence of staff being involved in learning from incidents or sharing good practice across teams and departments.

There had been an investment in the staffing for the service and it had seen an increase in the numbers of nurses. Despite this, District Nursing teams were still under-staffed and taking on increasing workloads. Staffing shortfalls meant that nurses could not attend mandatory and other training. Staff did not always reduce risks to themselves by following the lone working policies that were in place.

Nursing and therapy staff had a good understanding of safeguarding procedures and demonstrated where safeguarding concerns had been acted upon appropriately.

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers and, the early identification of an individual's risk of fracture. We saw elements of good practice including clean clinic areas, good infection prevention and control practice and, the use of independent and community nurse prescribers.

Incident reporting, learning and improvement

- There were 14 serious incidents between January 2014 and January 2015. Eight of these incidents had occurred in people's own homes and related to pressure ulcers. All of the other incidents related to wounds or injuries which later resulted in pressure ulcers developing. We saw that root cause analysis (RCA) investigations had taken place following these incidents and included actions or learning as a result. As a result, we saw where staff were participating in the 'stop the pressure' campaign. Senior managers told us this had contributed to a reduction in pressure damage.

- Staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system and were able to give examples of incidents they considered reportable. Examples included; broken or faulty equipment; medication errors and; staffing issues. However, we were not assured incidents were always reported correctly. Staff told us of incidents, one involving a potential safeguarding concern, one concerning an increase in calls to the evening district nursing service and another involving a persons health deteriorating. In each case staff took correct actions but they did not consider it necessary to report the incidents. This meant there was a risk trends in incidents were being missed and learning and improvements could not take place.
- Most staff within the clinics told us they always received feedback from incidents and gave us examples of where actions had been taken as a result. However, staff from the district nursing service told us they received very little feedback from incidents they had reported. Throughout our inspection we found little evidence of staff being involved in learning from incidents or sharing good practice across teams and departments. During our inspection we held a meeting for senior nurses and allied health professionals. During this meeting nine out ten staff told us they had not received feedback following an incident they had reported. Before our inspection we asked the trust for examples of ways in which information had been used to improve care. The trust response indicated that learning did take place however, lessons learned were not documented

Duty of Candour

- NHS hospitals have a responsibility to inform patients when things have gone wrong and harm has been caused. We discussed the Duty of Candour with the service leads for community. Service leads confirmed a prompt had now been added to the trust online reporting system. Staff could not complete an entry until they had acknowledged the prompt to address duty of candour.

Safeguarding

- All the staff we spoke with had an understanding of how to protect people from abuse. We spoke with staff who

could describe what safeguarding was and the process that should be followed to refer concerns. Staff gave us many examples of where they had raised safeguarding concerns and the processes they followed.

- The overall uptake of safeguarding adults and children's training across community health services for adults was significantly below the trust target of 95%. The nursing teams' level of compliance was considerably worse than the allied health professionals (AHP). For example, AHP compliance in level two safeguarding adults training was 29% in comparison to 16% for nursing staff and, AHP compliance in level two safeguarding children training was 60% in comparison to 32% for nursing.

Medicines management

- Throughout community health services for adults there was 38 independent nurse prescribers and 31 community nurse prescribers. Independent nurse prescribers are specially trained nurses allowed to prescribe any licensed and unlicensed drugs within their clinical competence. Nurse prescribers have full access to the British National Formulary (BNF) and work on a par with doctors in relation to their prescribing capabilities. Community nurse prescribers are a distinct group under independent prescribers. They are allowed to independently prescribe from a limited formulary called the Nursing Formulary for Community Practitioners which includes over-the-counter drugs, wound dressings and applications. Both groups of prescribers allowed for better care for people through faster access to medicines.

Safety of equipment

- Provision and maintenance of equipment was managed by the Rotherham Equipment and Wheelchair service. This was a joint service which was funded and commissioned by both health and social care services. It was dedicated to the provision of equipment for people, community nursing equipment and NHS prescription wheelchairs to the local community within Rotherham.
- Staff were able to access equipment for people if their risk assessment indicated it was required. For example if a persons' Waterlow score indicated that a pressure relieving mattress was required. Most staff assured us they would be able to order this equipment and it would be delivered in a timely manner. However, staff

did report having to request pressure relieving equipment through the trust tissue viability specialist team. Staff told us they felt this undermined their professional judgement and often caused delays in people receiving the equipment.

- Equipment required out of hours could be requested through the nursing bleep holder at the acute trust.

Records and management

- Staff used an electronic system to access people's records. This enabled them to also access GP records that included the person's medical history and investigation results and, online access to the person's treatment results, radiology and bloods results.
- Community nurses told us they had access to a laptop but sometimes chose not to use it in people's homes because they felt the use of a laptop device may cause a barrier or distraction between themselves and the person. As a result staff were making written notes in the person's home and updating the electronic care records once they had returned to their base. This meant the electronic record was not always completed at the time of the visit and there was a risk the paper notes may not always be identical to the electronic care record.
- Throughout community services for adults we found patient identifiable information was stored securely and electronic records were protected by password access.
- There were systems and protocols in place for sharing information with other professionals such as with GPs. Staff were aware of the requirements to maintain people's confidentiality at all times.
- Information governance training was mandatory. seventy six per-cent of allied health professionals and 62% of nursing staff had completed information governance training against a trust target of 95%.

Cleanliness, infection control and hygiene

- Staff were aware of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Throughout our inspection we observed staff using personal protective equipment appropriately. During visits to people's homes we observed nurses sanitising their hands before and after contact with people.

Mandatory training

- We received mixed feedback regarding mandatory training. Whilst most clinic staff told us they were up to date with mandatory training, district nursing staff told us they were not up to date and reported challenges with attending training due to their caseloads. Where staff were able to access the trust e-learning training, staff told us the system was often 'slow' and it could sometimes take up to 20 minutes to access the training. Staff told us if they had waited 20 minutes they would abandon the training and have to access it at a later date.
- Information received from the trust indicated that for nurses and allied health professionals (AHP) the overall target rate for mandatory training was 95%. Mandatory training topics had been identified as; dementia awareness; information governance; moving and handling; resuscitation; safeguarding adults (levels two and three) and safeguarding children (levels two, three and four). With the exception of safeguarding children training (level three) we saw that compliance across both staff groups was significantly below the trust target of 95% as of 31 January 2015.
- Training identified at a local level was conflict resolution; display screen equipment training; equality and diversity; fire and; venous thromboembolism (VTE). Compliance across both staff groups in all five areas was significantly below the trust target of 95% as of 31 January 2015.

Lone and remote working

- The trust had a policy for managing the security of lone workers. All community staff we spoke with were aware of the lone worker policy and the procedures that should be followed. However we found there were occasions when these policies were not followed. For example, staff in the district nursing teams told us there were times when some staff had not reported back to base when they had finished their visits.
- Staff told us where the level of risks indicated it was necessary, community staff worked in pairs, an alert was placed on the persons electronic care record and, staff would have contact details for a named individual in the event of an emergency. All staff had access to mobile phones.

Assessing and responding to patient risk

- Risk assessments were carried out for people who used services and we saw that risk management plans were

developed in line with national guidance. For example, in the bone health clinic we saw where a fracture risk assessment tool developed by the World Health Organization was used to assess an individual's risk of fracture. It was also used to provide clinical guidance for treatment decisions. In the falls and fracture clinic an assessment of falls risk in older people was completed using a nationally recognised falls risk assessment tool.

- We looked at 11 patient care and treatment records and saw that clinical risk assessments, using nationally recognised tools, were completed and followed for people. Examples included; assessments for pressure ulcers and nutrition.
- Calls to the care coordination centre were handled by band six registered nurses and received calls from local GP's. We saw that staff followed a proforma for a range of conditions and services. Examples included; oncology; venous thromboembolism; sepsis; discharge to assess and; intravenous pathway. This meant staff could advise the caller appropriately.

Staffing levels and caseload

- Staffing establishments were reviewed by the trust in conjunction with the Commissioners in 2014 utilising a recognised formula to determine the number of staff required in the service. As a result of this review, an additional seven registered nurses at band 5 and seven new Community Nursing Locality Lead posts (band seven) were provided. This meant the establishment was increased by 14 new posts and was a significant investment. However at the same time, clinical activity increased and the service over-performed by almost 11% on what it was contracted to provide with its commissioners.
- With the exception of the community district nurse teams most staff felt staffing levels were appropriate to the service they delivered and reported very few vacancies. Staff within the community clinics reported having enough staff to enable the safe and effective delivery of care and treatment.
- As part of the trusts community transformation programme the structure of the district nursing and community matron services was reviewed in 2014. On 02 February 2015 the old structure of community nursing teams was split into seven teams based on a seven locality model where teams started to serve GP practice populations.

- Most staff we spoke with within the district nursing teams experienced difficulty in managing their caseloads on a daily basis. Staff felt current vacancies; maternity leave and staff sickness had a negative impact on staffing levels within the seven teams. Staff told us they regularly worked over their contracted hours, worked without taking breaks, completed online patient records at home on their work laptops and, felt 'stressed' due to work commitments. We were told of newly qualified staff leaving within three months of employment due to staffing pressures and, staff crying on a daily basis as a result of stress.
- Information received during our inspection indicated the combined nursing establishment for band six and seven district nurses across the seven teams was 22.67 whole time equivalents (WTE). We saw that this staff group was carrying a vacancy rate of 31% (seven vacant posts).
- The combined nursing establishment for band five community staff nurses across the seven teams was 84.5 WTE. This staff group was carrying a vacancy rate of 6% with an additional 4% vacancy due to maternity leave. We were unable to determine the current sickness rates for the seven teams. However, during the week of our inspection the central north team had two out of seven staff off due to sickness.
- We saw that staff in the district nursing teams recorded the actual number of nursing staff against the minimum number of staff required to deliver safe care. This was completed each week and discussed at a weekly 'huddle' meeting with the service lead. Over the previous seven day period across the seven localities a total of 40% of shifts were below the described optimal staffing level.
- Caseloads for the district community nursing teams were calculated on a daily basis for the following day. This was usually completed by a nurse who had been specifically allocated to schedule visits. On the day of our inspection a band five staff nurse was scheduling visits for the following day. However, this nurse was not always aware of the competencies of the nurses they were allocating caseloads to. An example of this was the allocation of compression bandaging to a nurse who was not competent to carry out this procedure.
- Visits were scheduled according to patient dependency. With one dependency being equal to a 15 minute visit that included travelling time. Some people had a higher dependency score and required a longer visit. For

example, people who required the dressing of bilateral venous leg ulcers were categorised as four dependencies and as such staff were allocated 60 minutes to visit the person. On the day of our inspection one member of staff told us their caseload was made up of 21 dependencies which meant there would be almost three hours of the working day to access training or emails. The nurse told us they felt their caseloads were usually higher than this and they had little time for other activities.

- We discussed staffing levels with senior managers, they had listened to the concerns of the nursing staff and were trying to address this, but there were difficulties recruiting permanent staff. They told us recruitment was underway and staffing had been identified on the trust risk register as an amber risk, this meant the risk had been considered as 'moderate' priority. Senior managers told us of twice weekly 'huddles' with the band seven team managers and the service lead, this allowed staff the opportunity to discuss staffing issues

throughout community services. The service lead also discussed the development of a flexible workforce through the use of a nurse bank specifically for community health services for adults. In addition, staff were offered to work additional hours and over time.

Managing anticipated risks / Major incident awareness and training

- In the past year there had been no emergencies or major incidents. The adult community services would respond to an emergency situation utilising its business continuity plans and would respond to a major incident in line with the trust major incident policy.
- Through the trust risk assessment process we saw where community services for adults had identified potential risks that could have a negative impact on service delivery. Examples included; adverse weather conditions; utility failure; an act of terrorism and; a pandemic.

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.

The effectiveness of the community health services for adults required improvement.

District nursing staff reported difficulties accessing training and supervising new staff due to low staffing levels. Some staff were appropriately qualified, skilled and competent to carry out their roles and worked well to meet the needs of patients.

We saw that systems were in place to enhance the delivery of effective care and treatment through the care coordination centre, telehealth and electronic care records. However, connectivity issues, lack of information technology equipment and, inconsistency of patient record systems meant staff did not always have the relevant information available prior to attending to a person's healthcare needs.

We found some staff were unsure of their responsibilities in relation to people who lacked the capacity to make decisions about care or treatment, in line with the Mental Capacity Act (2005).

Evidence based assessment, care and treatment was delivered in line with national guidance and NICE quality standards. Staff regularly monitored the outcomes of people's care and treatment and information we reviewed indicated that outcomes were largely positive.

A multi-disciplinary team approach was evident across all community health services for adults. We observed good multi-disciplinary working throughout the clinics and teams we inspected and saw there was a shared responsibility for care and treatment throughout the teams.

Evidence based care and treatment

- Care and treatment were evidence based and staff followed best practice recommendations. For example, the bone health service followed guidance from the National Osteoporosis Society (NOS) and the National Institute for Health and Care Excellence (NICE). This included early diagnosis of osteoporosis through dual energy X-ray absorptiometry (DEXA) scans and,

appropriate treatment options through the use of steroid therapy. Clinical staff followed guidance relating to falls assessment and prevention, nutrition support, venous thromboembolism and sepsis.

- Recognised rehabilitation measures were used. For example, physiotherapists in the falls and fracture clinic used the Tinetti Performance Oriented Mobility Assessment, designed to measure balance (including fall risk) and gait function.
- Pressure ulcer prevention and treatment was delivered in line with NICE guidance. We saw that pressure ulcer prevention leaflets following NICE guidance were given to all people who had been identified as being at risk of developing pressure damage.
- We observed staff following national guidance in relation to wound dressings using the aseptic non touch technique (ANTT).
- We saw that therapists throughout community health services for adults carried out evidence based treatment of people with a wide range of health care needs.

Use of technology and telemedicine

- The care coordination centre (CCC) was a resource available to GP's; enabling GP's to make informed choices about the best level of care for people. The CCC used real time information on system capacity to support GPs. It organised transport when appropriate and provided real time communication to clinicians as to where the person was in the system. The service provided alternative community-based diagnostic and treatment pathways in for example; deep vein thrombosis, temporal arteritis and sepsis. The service also supported discharge planning with follow-up telephone support to people who were at high risk of readmission.
- Through the use of telehealth the CCC supported the case management of people within heart failure services. Telehealth is the delivery of health-related services and information via telecommunications technologies. Through the monitoring of a person's

Are community health services for adults effective?

heart rate and blood pressure within their own home, staff within the CCC were able to monitor the person's condition remotely and escalate to the heart failure nurse specialist where appropriate.

Approach to monitoring quality and outcomes of care and treatment

- Community service leads participated in performance review meetings, which focused on patient outcomes with commissioners.
- The falls and fracture clinic delivered an accredited weekly exercise based group called "Otago." Otago is a series of seated and standing exercises adapted for all abilities. It is designed to improve a person's strength, balance and coordination, and help reduce the risk of falling. For those people who were 'housebound', staff were trained to deliver the Otago programme in the person's own home.
- In October 2014 the community integration service completed an audit of consistency of paperwork completed on discharge to identify whether staff were consistently and accurately completing all aspects of the discharge paperwork. Six standards of documentation were assessed. This audit highlighted poor compliance with all six standards. Information received before our inspection showed that actions had been taken as a result of these findings. These included; raising awareness of the inconsistencies and demonstrating the importance of completing discharge paperwork; liaising with the occupational therapy manager regarding the impact staffing levels was having on the service and; introducing a discharge checklist into each person's file to be used as a prompt for discharge.
- The Podiatric Surgery department reported good outcomes for patients with a 98% success rate following surgery and, 0.5% surgical site infection rate. Outcomes for people were published and each person treated received a copy of the results.
- We saw that people attending the park rehabilitation centre had their progress and outcomes recorded. People said they were very pleased with the service and that they had improved since coming to the centre.
- The Park Rehabilitation Centre monitored the outcomes of those patients who had attended for rehabilitation following a stroke. This included monitoring peoples'

personal goals of returning to work. On one occupational therapists caseload, eight people had a personal goal of returning to work. Of these, five returned to some form of employment.

Competent staff

- Training packages were available for nursing staff. These included; leg ulcer assessment; leg ulcer management; application of compression bandages; application of short stretch bandages; vascular assessment; a compression therapy workshop; equipment training and wound assessment and management. We were unable to determine the number of nursing staff who had completed this training.
- Some staff in district nursing services told us although they were unable to access mandatory training because of low staffing levels. We found that one member of staff had not completed their competency training even though they had been in post for five months. This was because their mentor was unable to complete their training due to their own workload. On the day of our inspection one of the nurses had been allocated a person who required venous leg ulcer dressings. The nurse this had been allocated to was not appropriately trained in this procedure and as a result caseloads between staff had had to be rearranged.
- We were unable to determine the overall numbers of community staff who were up to date with their mandatory training.
- Staff working at the care coordination centre received training appropriate to their role this included a four-week induction on the medical admissions unit at the acute trust.
- Staff within the cardiac rehabilitation service reported good access to training appropriate to their roles with joint funding between the trust and the British Heart Foundation, which provided up to £1000 per staff member to access external training.
- We received mixed feedback from staff regarding their appraisal. Not all community staff had received an appraisal in the last year. An appraisal provides staff with the opportunity to receive feedback on their progress, set objectives for the coming year and identify learning and development needs. To date from April 2014 approximately 84% of staff had received an appraisal.

Are community health services for adults effective?

- Therapy staff received regular supervision from their line managers. Staff told us they had protected time every six weeks, which contributed to their continuing professional development.

Multi-disciplinary working and coordination of care pathways

- Community health services for adults delivered services through integrated clinical pathways across the population of Rotherham. All of the clinical pathways were supported by services that included adult community nursing, community matrons, continence services, fast response, long term conditions teams and intermediate care.
- We saw evidence of effective multidisciplinary working throughout our inspection. For example, the bone health clinic was led by a band 7 clinical nurse specialist who worked alongside a consultant endocrinologist. The falls clinic included occupational and physiotherapy services.
- Within community services nursing and therapy staff worked across two different clinical directorates. This meant staff were often based in different locations of the trust. Nursing staff told us this meant it was not always easy to ensure patient needs were met in a timely manner.
- Within the Podiatric Surgery department we observed excellent multidisciplinary working amongst the team which was led by a consultant podiatric surgeon. This was a specialist service which provided assessment and treatment of foot and ankle conditions usually involving having an operation. There were clear patient pathways with referrals either from the persons GP or other healthcare professionals.
- Within the podiatry clinic staff told us that a multidisciplinary diabetic meeting was held once a month. This meeting enabled a multidisciplinary approach to the care of people who had been diagnosed with diabetes.

Referral, transfer, discharge and transition

- Most referrals to the bone health clinic were via each person's GP, the emergency department or, the community matron and were usually the result of a fall where the person had sustained a fracture.
- In daytime hours the majority of referrals to the district and community services came through an electronic system. A few referrals came via an a facsimile system.

Staff felt, at times, this system was ineffective. A new system was being developed to provide a single point of referral and this would rectify the problems with the facsimile system.

- During our inspection we spoke with the carer of a young person who had recently transitioned from children's services to adult services. They raised no concerns about community adult services and were positive about the facilities now available to their relative.

Availability of information

- Most staff we spoke with had no problems accessing people's records. However, some staff told us of connectivity issues. Therapy staff within the Park Rehabilitation Centre told us the records of people who were referred for treatment following an admission to the acute trust were not always up to date before they were seen at the centre. A new member of staff told us they had to wait five months before they were given a computer. This meant they did not have access to information when they undertook home visits. The trust had invested £190,000 during 2013/14 on new lap tops for community teams and they told us they were due to get more in the coming months.

Consent

- Staff told us they were aware of, and had access to, the trust policy and procedures for consent. Consent was sought from people prior to the delivery of treatment. People we spoke with told us that they felt involved in decisions about their care.
- Staff demonstrated confidence in seeking valid consent to treatment from people. They explained things to people in a way that they could understand and helped them make informed decisions.
- However, not all staff were aware of their responsibilities in relation to people who lacked the capacity to make decisions about care or treatment, in line with the Mental Capacity Act (MCA) (2005). Staff were unclear about the procedures to follow when reaching decisions in persons' best interests. Most staff told us they would not be involved in completing a mental capacity assessment but would approach the persons' GP or next of kin to gain consent.
- During one visit to a persons' home we saw a person living with dementia. Whilst at the time the person was able to give consent, following further discussion with

Are community health services for adults effective?

the nurse we were told had the person not given consent to treatment a mental capacity assessment would not have been completed by the nurse. They told us they would contact the GP. We could not therefore be assured staff were working in accordance with the MCA code of practice (2005).

- Information received following our inspection showed the overall uptake of dementia awareness training

across community health services for adults to be significantly below the trust target of 95% with both nursing and allied health professionals (AHP) level of compliance at 4%.

- We discussed MCA awareness and training with a team leader who told us a need for training in this area had been identified.

Are community health services for adults caring?

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

The care afforded to patients was good.

People who received care were treated with compassion and respect. Staff worked hard to ensure people received a high level of care. All the patients we spoke with were consistently positive about the care they received.

Dignity, respect and compassionate care

- People who received community health services for adults were treated with compassion, dignity and respect. All of the people we spoke with were positive about the care they received. During the home visits we observed staff interacting with people in a respectful and considerate manner.
- Throughout community health services for adults we saw that staff introduced themselves when meeting new people and explained to people what care they were going to provide. Staff spoke to people in a kind and caring way and we saw that people were treated with dignity and respect.
- The trust submitted data via the NHS friends and family test (FFT). The FFT gives people the opportunity to provide feedback on the services that provide care and treatment. Across community health services for adults from April to December 2014 the average FFT score was 98%. This suggested patient satisfaction was high.

Patient understanding and involvement

- We saw that staff discussed planned care and treatment with people and where necessary provided information

to reinforce understanding. We saw a nurse in the bone health clinic taking great care to ensure the person understood what was going to happen throughout their treatment.

- We also saw that staff involved families and carers in the care planning process. We saw that staff delivered person centred care; this meant that people's individual needs were taken into account when their care was being planned. People said they were very happy with their care. One person said "The team is really good. I like them to come".

Emotional support

- Community staff considered emotional support as part of their assessment and could refer to appropriate support services where appropriate.
- The public and staff had access to clinical nurse specialists across community services. For example, we saw that there were specialist nurses for Parkinson's, heart failure services, continence and, tissue viability.

Promotion of self-care

- During home visits with the district nursing teams we saw that people were supported to manage their own health and care and maintain their independence.
- Within the clinics we saw that, as part of the assessment process, people were asked about their usual activities of daily living.

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.

The responsiveness of the community health services for adults service was good.

All of the people we spoke with confirmed their healthcare needs were being met and were full of praise for the service they received. Performance data demonstrated access to care and treatment was mostly in line with or, better than the trust target.

There were a range of initiatives to ensure patients received the care they needed both to remain at home without hospital admission and to leave hospital swiftly with appropriate multidisciplinary care in the community. Clinics were mostly responsive to people's needs with good access to care but in some clinics there was no provision to staff the clinic in the absence of the lead registered nurse, this led to clinics being cancelled.

Staff knew how to access interpreters for patients whose first language was not English. However, most staff said they would use a relative or carer to interpret and had not considered the risks of misinterpretation of information or, confidentiality.

Staff demonstrated a good awareness of the trust complaints procedure and how to deal with complaints. However, most staff told us they did not receive feedback from complaints. This meant people's concerns, comments and complaints were not used systematically as an opportunity to learn.

Planning and delivering services which meet people's needs

- Services within the bone health and the falls and fracture clinic were commissioned on the basis of the population they served. However, nursing staff told us not all GPs were aware of the services. This meant people who may benefit from these services were not always appropriately referred.
- Provision and maintenance of equipment was managed by the Rotherham Equipment and Wheelchair service. This was a joint service with the local authority, dedicated to the provision of daily living assistive aids, community nursing equipment, and NHS prescription wheelchairs, to the local community within Rotherham.

- Staff at the care coordination centre told us they sometimes experienced problems with patient transport, this was often due to capacity issues at the acute trust or, during adverse weather conditions. In order to minimise the impact to people a service level agreement was in place with a local car dealer who would supply a four-wheel drive vehicle to be driven by a member of staff for the transportation of people to and from the trust.
- Staff within the fast response service worked closely with other services provided by the local authority. One example given was of a 'turning' service which was available out-of-hours. This service provided pressure relieving support in people's homes to reduce the likelihood of a person developing pressure damage.
- Out of hours support for district nursing services was provided by the fast response team and the district nursing evening and night service. However, between the hours of 0200 and 0700 staff told us only one district nurse and one support worker were available to support the population of Rotherham. Additional support was provided by the local authority, social services and a local charity. Information provided by the trust showed the number of district nurse contacts between these hours to be 62 for November 2014; 49 for December 2014 and, 60 for January 2015. It was unclear from these figures how many contacts were made at night. We were not made aware whether the staffing overnight had been raised as a risk for community services or if provision had been made for staff sickness or absence or an increase in the needs of the local population.
- Staffing levels had been increased within the diabetic service due to the rising numbers of people with diabetes.

Equality and diversity

- Provision was made for people who did not have English as their first language. Most staff knew how to access interpreter services but many told us they would use the services of a relative or carer. Using a relative or carer to interpret could result in miscommunication between the patient and the healthcare professional.

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

- Most staff we spoke with were not aware if written information could be provided in other languages or in large print.

Meeting the needs of people in vulnerable circumstances

- There were systems in place to identify cognitive impairment symptoms in patients. For example, staff within the falls and fracture clinic completed the six item cognitive impairment test as part of their initial assessment.
- A fast response service was available within community health services for adults. The fast response team provided crisis intervention from 07:00hrs to 02:00hrs seven days a week and worked to prevent unnecessary admission to hospital. The team provided intensive nursing and therapy in people's own homes, providing an alternative to hospital care. Where care could not be provided in the person's own home, they provided care in a nurse led bed in either a residential or nursing home for up to two weeks.
- Within the audiology service we saw that a 'one-stop' shop was in place where people could come to the clinic and have their hearing needs attended to. If they required a specific type of hearing aid they were able to access the audiology care they needed and be fitted with one on the same day. Staff told us this was a unique service.

Access to the right care at the right time

- Service leads monitored the quality of the service through a range of different outcome measures. Outcomes were monitored on a monthly basis and reported through the community performance report. Performance scores indicated the proportion of priority one and priority two contacts seen within 24 hours by the community nursing team from April to December 2014 was 92% against a trust target of 95%. The proportion of patients on the community nursing case load with a care plan that had been reviewed within the last six months from April to December 2014 was 92% against a trust target of 95%.
- Within the fast response service the proportion of people who were seen for an initial assessment within two hours of referral was 92% and exceeded the trust target of 80%. The proportion of patients assessed as non-urgent within 28 working days of receipt of referral was in line with the trust target of 95%.

- Staff told us they had to prioritise visits on a daily basis and it was not uncommon to reschedule visits. In order to understand the extent of rescheduling one of the teams were completing a 'daily demand and capacity' log. This recorded staffing numbers for the day, the number of patient visits, the number of patients rescheduled and, any unplanned visits.
- The health care of older person (HCOP) consultants and nurse consultants worked across the hospital and community services in order to support the seven community teams, providing expertise and guidance.
- The bone health clinic ran two nurse-led sessions every Tuesday and Thursday morning and, a consultant-led clinic every Wednesday afternoon and alternate Tuesday afternoons. Staff told us the number of clinics was sufficient with most people receiving an appointment within three days of their referral and, a DEXA scan within ten days of their appointment. However, nursing staff told us clinics would be cancelled if the nurse was on leave, attending training or, absent due to sickness. In these circumstances clinics would see more people the week before or after the cancelled clinic.
- Two falls and fracture clinics were held weekly for people aged between 50 and 75. For people over the age of 75 there was a weekly clinic in addition to a home visit. Clinics were run by a registered nurse who told us if they were off sick or on leave the clinic would usually be cancelled.
- Referrals to the falls and fracture clinic were made via a person's GP and, the emergency department if the fall had resulted in harm or a person had experienced two or more falls. Assessments were carried out either in the falls and fracture clinic or in the person's own home. At the time of our inspection the waiting list for home assessments was four. Nursing staff told us during the last year this had been as high as 50 to 60.
- The care coordination centre provided real-time support to GP's seven days a week; 0800-2200 Monday to Friday and; 1000-1800 over the weekend. Out of hours support for GP's was via the acute trust medical 'on-call' registrar.
- Waiting times for the community podiatry service were two weeks from referral to appointment and, two weeks from the first appointment to treatment. Staff said they were able to meet the demands on the service and they did not have a waiting list. People were also able to access a rapid response service by attending the clinic

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

early morning. The clinical lead told us they were trying to change this so that patients could have choice about what time they came rather than having to come early morning. Staff said they would also visit people in their homes if they were unable to come to clinic.

- The domiciliary physiotherapy service provided a home physiotherapy service to help patients continue to live at home or in their nursing or residential home in order to be as independent as possible. They aimed to reduce unnecessary hospital admissions by addressing the persons' problems in their own home by assessing, treating, advising and providing aids and equipment where necessary.

Complaints handling (for this service) and learning from feedback

- Across community services staff told us the process for dealing with complaints which included local resolution in the first instance. Staff in the care coordination centre told us they received few complaints but would escalate to the bleep holder at the acute trust when required.

- Senior nurses told us an online complaints log was managed and information regarding complaints would be shared at the trust clinical governance group.
- There were 56 complaints received by the trust which related to community services but these also included the dental and therapy services. Of these, 17 complaints were managed through the formal route and the remainder were managed as informal concerns.
- Most staff told us they did not receive feedback from complaints. This was largely due to being unable to attend team meetings. Before our inspection we asked the trust for examples of complaints and how lessons learned were shared with others. Whilst we saw that complaints had been fully investigated by the service lead for community services, the trust told us it was not possible to obtain evidence or examples of how lessons were shared with the teams. The Directorate service lead advised that a variety of methods including team meetings and staff forums were used but there was no evidence available to support this.

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.

The leadership in the community health service for adults required improvement.

Although there were measures in place to manage risks throughout the service, we could not be assured there were effective governance arrangements in place involving all staff. We found there was a lack of understanding in relation to how learning from incidents and complaints was implemented and opportunities for sharing learning and, engaging with other staff as part of community wide services were not well established.

Communication between some teams was limited with little opportunity to raise concerns. We met with some dedicated, innovative staff who demonstrated the values of the trust, were passionate about their jobs and, were proud of their work but felt 'ignored' by key staff at the acute trust. Staff were uncertain as to whether the trust board was aware of some services provided in the community, this left many staff feeling de-valued. The trust board were aware staff didn't feel engaged and had a number of actions in place to address this. This was still work in progress at the time of our inspection.

Service vision and strategy

- We saw the trusts' strategic plan document for 2014 to 2019 which reflected the current shared vision and strategy of the trust Board. Within this strategy we saw reference to community services with the emphasis on reducing staff sickness absence levels, increasing appraisals and improving staff satisfaction and; the community transformation programme: 'managing long term conditions in non-acute settings'. Most staff we spoke with had attended the trust briefing sessions held by the chief executive but were still unclear about the vision for community services. Whilst staff spoke of an 'integrated' trust they had no understanding of how this was going to be achieved.
- Whilst staff felt the trust board had no real understanding of community services, it was clear that the trust was focused on community services, and in

particular, had prioritised integration. The trust had a Community Transformation Programme, for which the trust secured £5million investment from their commissioners against an agreed set of objectives.

Governance, risk management and quality measurement

- With the exception of the community district nurse teams most other staff told us there were robust governance arrangement in place through team meetings, leadership meetings, clinical governance meetings, regional peer review groups and regular audits.
- Most staff within the district nursing teams told us they rarely attended department meetings due to their caseloads. One member of staff told us they had last attended a team meeting in November 2014. Staff working across more than one clinical directorate often found it difficult to arrange a meeting between different staff groups. Where meetings had taken place minutes were not always taken to allow non-attenders an update of discussions that had taken place. One to one meetings with line managers were described as 'ad hoc'.
- Band seven team leaders told us maintaining effective communication throughout teams was difficult. Handovers took place between the community teams in the afternoons but were often poorly attended due to staff caseloads. In order to improve communication the team leaders would contact individual nurses by telephone and group texts were also used.
- Staff within the district nursing teams reported feeling unsupported in their roles. Where they had once been able to request a second member of staff to attend a home visit for advice and support this was no longer possible due to staff shortages and an increasing caseload.
- Across most of community health services for adults we found there was a lack of understanding in relation to how learning from incidents and complaints was implemented. This meant there was a lost opportunity for staff who had been unable to attend to be updated on possible changes to the service as a result of incidents or complaints.

Are community health services for adults well-led?

- The community nursing team were monitoring the number of visits that had to be rescheduled and we saw where a log was completed. We could not be assured the information was acted upon at a higher level. Staff thought senior managers saw the results but were unsure.

Leadership of this service

- The executive team had been out to meet with some of the District Nurses and the Chairman and Chief Executive had been out to present to community teams. The Chief Nurse had visited the evening and rapid response service several times and had held an evening dinner with a group of district nurses and ward sisters to initiate more integrated working within nursing. Despite this, some staff did not feel supported by the wider acute trust management team. Many staff described community services as the 'poor relation to the acute trust.' Most staff reported feeling well supported by their immediate line managers.
- A community transformation programme, led by the Chief Operating Officer was in place and would address the integration and engagement with community staff.
- Staff told us of a 'historical' lack of leadership at band seven. This had since been addressed by the trust following the introduction of the seven-locality model within district nursing services.
- Where staff were aware of the trust chief executive they were very positive about the appointment and leadership style.
- Band seven community nurses reported good communication with their band seven colleagues and immediate line managers. Band seven nurses are team leaders. Twice weekly meetings took place on a Monday morning and Thursday afternoon. This gave team leaders the opportunity to discuss issues such as staffing, incidents and, complaints, It was also an opportunity for development amongst the band seven's with guest speakers attending on a weekly basis.
- There was a regular team brief throughout the trust and every month it was delivered in a community setting.

Culture within this service

- Staff at all levels reported feeling that community health services for adults were not an integrated part of the trust and were not given as much priority as acute services. Where policies and procedures were in place, staff felt these related to acute services.

- Community nursing teams thought staff and managers in the acute hospital had a poor understanding of community services. Many staff told us it felt like the acute trust did not know their service existed. Staff working in allied health professions were generally more positive about this.
- In order to integrate acute and community services across the medical directorate the service leads had introduced a staff 'away-day'. This allowed staff the opportunity to learn about others' roles and responsibilities and ensured all staff received the same message with regards to the integration of the trust. We were told 1300 invites were sent to the first event with 90 staff attending.
- With the exception of the community nurses, staff demonstrated an awareness of the vision and values of the trust. Staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed under what appeared to be very challenging conditions.

Public and staff engagement

- We spoke with patients attending the podiatry service. All were positive about the care they had experienced. This service monitored the level of patient satisfaction and the most recent patient satisfaction results were 97%.
- Throughout community services for adults morale was low. Line managers reported staff morale rising and falling on a daily basis. Staff repeatedly told us there was a lack of vision for community services which left them feeling vulnerable and uncertain about their future. Within one staff group a 30-day consultation was in progress to look at extended working hours and job descriptions. Staff within this group did not feel involved and, at the time of our inspection, had no immediate line manager in post to offer reassurance. Staff told us the reconfiguration of services had been very unsettling, they felt there had been no clarity from senior management when information had been given to staff. Staff told us they felt devalued and that the trust was not being open and honest with them.
- All the staff we spoke with assured us they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We were also told that staff had the opportunity to email the chief executive via a "Dear Louise" mailbox. However, some staff felt, where they had raised issues action had not been taken.

Are community health services for adults well-led?

- Where staff had been involved in staff meetings they felt they had been made to feel guilty for raising concerns. The trust had run sessions called, "moving forward together," these were joint sessions with acute and community staff where they could raise concerns. We heard of some examples where different staff groups had worked to find a solution the identified concerns and this had helped to promote integration of services.
- Within the Podiatric Surgery department, senior staff told us they had spoken to the board and asked for their support to change the service to enable staff to take on more complex care. This meant that some areas of care, such as nail cutting, would not be provided but patients would be given advice on how to access this. Senior staff said that the board had supported their proposal and that staff were now able to see patients with more complex care needs which was helping to meet the needs of the local population.

Innovation, improvement and sustainability

- Community health services for adults had a number of initiatives to support early discharge from the acute hospital and to prevent avoidable hospital admissions. These included the care coordination centre and, the fast response team.

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

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing

The provider must ensure there are sufficient numbers of suitably qualified and skilled staff to meet the needs of people who uses the services.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities)
Regulations 2010 Consent to care and treatment

The provider must ensure staff are working in accordance with the Mental capacity Act code of practice (2005).

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities)
Regulations 2010 Supporting staff

The provider must ensure that all community health services for adults' staff are able to attend mandatory training and other essential training as required by the needs of the service.