Somerset Partnership NHS Foundation Trust

RH5

Community health services for adults

Quality Report

2nd Floor, Mallard Court, Express Park,
Bridgewater, Somerset, TA6 4RN
Tel: 01278432000
Website: www.sompar.nhs.uk

Date of inspection visit: 7,8,9,10,11 Sept 2015
Date of publication: 17/12/2015

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5X5	Dene Barton Community Hospital		TA4 1DD
	Park Gate House		
RH5F8	West Mendip Community Hospital		BA6 8JD
	Priory House		
	Charter House		
RH5X3	Chard Community Hospital		TA20 1NF
RH5G5	Frome Medical Centre		BA11 2FH
RH5Y8	South Petherton Community Hospital		TA13 5EF
RH5X4	Crewkerne Community Hospital		TA18 8BG
RH5X7	Williton Community Hospital		TA4 4RA
RH5F7	Shepton Mallet Community Hospital		BA4 4PG
RH5X9	Wellington Community Hospital		TA21 8QQ

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service requires improvement

We rated the safety of community health services for adults as 'inadequate'. Investigation of incidents was thorough but shared learning was not reliable. Staff shortages were evident and lack of a staffing tool resulted in ineffective oversight of safe staffing levels. The duplication of record keeping in paper and electronic format led to omissions of important information essential for safe patient care. Clinical risk assessments relating to nutrition, pressure care and falls were not consistently completed or reviewed. Wound assessments were not sufficiently thorough. Staff knew how to raise a safeguarding concern however, the level of training for safeguarding children was below recommended guidelines. Compliance with mandatory training varied. Some nursing equipment was stored beyond its expiry date, meaning that there was no guarantee of the sterility of the items. However, there were adequate systems in place for cleaning, maintaining and disposing of equipment.

We rated the effectiveness of community health services for adults as 'requires improvement'. Staff working in patients' homes did not always have access to the information needed to deliver effective care because they could not connect to the electronic record keeping system. Staff assessed patients' pain but did not use a standardised tool to help them to do this. Staff screened patients for nutritional needs but this was inconsistent. Therapists used individual outcome measures to monitor patients' progress, and some specialist teams used outcome measures and patient reported experience measures to benchmark the performance of the service. However, the district nursing and independent rehabilitation teams did not use outcome measures to benchmark their performance. There were good examples of multidisciplinary working on a case-by-case basis but current systems did not encourage formalised multidisciplinary exchange. Although staff reported good access to training, there was mixed compliance with appraisals and a lack of consistent approach to the supervision of staff. Telehealth was used effectively to enhance care and treatment. Compliance assessments for National Institute for Health and Clinical Excellence guidelines had been completed for most relevant quality standards.

We rated community health services for adults as 'good' for caring. Patients were given emotional support to help them cope emotionally with their condition. Referrals could be made to the 'talking therapies' service for emotional health checks. The 'life after stroke' group at Williton provided emotional support for patients following stroke. We observed nurses and therapists giving care to patients. All interactions between staff and patients were respectful, professional and kind. Staff listened to patients and took care to protect their dignity. Staff used creative techniques to educate patients and relatives and encourage their understanding. Patients told us they felt involved in their care.

We rated responsiveness of community health services for adults as 'requires improvement'. District nursing and independent rehabilitation teams were usually available seven days a week and were able to respond to patients whose needs were urgent within 24 to 48 hours. However, patients with less urgent needs did not receive timely assessments. There were 865 patients who had waited more than six weeks for an assessment by the independent rehabilitation teams. Of these, 115 had waited more than 18 weeks. For podiatry, 88 patients had waited more than 18 weeks for an assessment. In speech and language therapy, some patients waited two weeks for staff to consider the urgency of their referral. There were good examples of learning from complaints, and projects such as the ambulatory care clinics were flexible to meet individual patient needs. However, people using services were not included in the planning and design of services in the district nursing and independent rehabilitation teams.

We rated community health services for adults as 'requires improvement' for its leadership. Staff were positive about the benefits of further integration but they did not know what their role would be in achieving the new vision of integrated care. Staff were not aware of their role in action plans for the key risks affecting the services. The system for ensuring the safety of staff working alone at night was not reliable. Public

Summary of findings

engagement was minimal within the larger services such as district nursing or the independent rehabilitation teams. Divisional risk registers reflected the risks evident in the teams but there was a lack of ownership of the risk associated with unreliable wireless internet connectivity, and leaders on the front line were not aware of progress with mitigation plans for key risks affecting the service. There were action plans in place to address the risk resulting from increased demand and decreased capacity in the district nursing service.

Summary of findings

Background to the service

We rated the safety of community health services for adults as 'inadequate'. Investigation of incidents was thorough but shared learning was not reliable. Staff shortages were evident and lack of a staffing tool resulted in ineffective oversight of safe staffing levels. The duplication of record keeping in paper and electronic format led to omissions of important information essential for safe patient care. Clinical risk assessments relating to nutrition, pressure care and falls were not consistently completed or reviewed. Wound assessments were not sufficiently thorough. Staff knew how to raise a safeguarding concern however; the level of training for safeguarding children was below recommended guidelines. Compliance with mandatory training varied. Some nursing equipment was stored beyond its expiry date, meaning that there was no guarantee of the sterility of the items. However, there were adequate systems in place for cleaning, maintaining and disposing of equipment.

We rated the effectiveness of community health services for adults as 'requires improvement'. Staff working in patients' homes did not always have access to the information needed to deliver effective care because they could not connect to the electronic record keeping system. Staff assessed patients' pain but did not use a standardised tool to help them to do this. Staff screened patients for nutritional needs but this was inconsistent. Therapists used individual outcome measures to monitor patients' progress, and some specialist teams used outcome measures and patient reported experience measures to benchmark the performance of the service. However, the district nursing and independent rehabilitation teams did not use outcome measures to benchmark their performance. There were good examples of multidisciplinary working on a case-by-case basis but current systems did not encourage formalised multidisciplinary exchange. Although staff reported good access to training, there was mixed compliance with appraisals and a lack of consistent approach to the supervision of staff. Telehealth was used effectively to enhance care and treatment. Compliance assessments for National Institute for Health and Clinical Excellence guidelines had been completed for most relevant quality standards

We rated community health services for adults as 'good' for caring. Patients were given emotional support to help them cope emotionally with their condition. Referrals could be made to the 'talking therapies' service for emotional health checks. The 'life after stroke' group at Williton provided emotional support for patients following stroke. We observed nurses and therapists giving care to patients. All interactions between staff and patients were respectful, professional and kind. Staff listened to patients and took care to protect their dignity. Staff used creative techniques to educate patients and relatives and encourage their understanding. Patients told us they felt involved in their care.

We rated responsiveness of community health services for adults as 'requires improvement'. District nursing and independent rehabilitation teams were usually available seven days a week and were able to respond to patients whose needs were urgent within 24 to 48 hours. However, patients with less urgent needs did not receive timely assessments. There were 865 patients who had waited more than six weeks for an assessment by the independent rehabilitation teams. Of these, 115 had waited more than 18 weeks. For podiatry, 88 patients had waited more than 18 weeks for an assessment. In speech and language therapy, some patients waited two weeks for staff to consider the urgency of their referral. There were good examples of learning from complaints, and projects such as the ambulatory care clinics were flexible to meet individual patient needs. However, people using services were not included in the planning and design of services in the district nursing and independent rehabilitation teams.

We rated community health services for adults as 'requires improvement' for its leadership. Staff were positive about the benefits of further integration but they did not know what their role would be in achieving the new vision of integrated care. Staff were not aware of their role in action plans for the key risks affecting the services. The system for ensuring the safety of staff working alone at night was not reliable. Public engagement was minimal within the larger services such as district nursing or the independent rehabilitation teams. Divisional risk registers reflected the risks evident

Summary of findings

in the teams but there was a lack of ownership of the risk associated with unreliable wireless internet connectivity, and leaders on the front line were not aware of progress with mitigation plans for key risks affecting the service. There were action plans in place to address the risk resulting from increased demand and decreased capacity in the district nursing service.

Our inspection team

Our inspection team was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Bennett-Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team included CQC inspectors, pharmacists, an analyst and inspection planners.

There were also specialist advisors from a variety of community health service

backgrounds, including consultants in community health services, senior nurses and social workers.

In addition, the team included experts by experience who had personal experience of using community health services or caring for someone who had used these services.

Why we carried out this inspection

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

How we carried out this inspection

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 the visit, the inspection team:

- reviewed information that we hold on the trust
- requested information from the trust and reviewed that information
- asked a range of other organisations that the trust works in partnership with for feedback these included NHS England, Somerset clinical commissioning group, Monitor, Healthwatch, overview and scrutiny committees,professional bodies and user and carer groups
- held three listening events before theinspection to hear the views of local people
- reviewed information from patients, carers and other groups received through our website.

What people who use the provider say

We spoke with 40 patients whilst on this inspection, and collected ten comment cards. Patients described feeling very satisfied with the services they had received. They reported that the staff were considerate, respectful and

Summary of findings

treated them as individuals. Patients described how they had achieved goals that were meaningful to them. They explained how the staff were there to offer support to them when they needed it. Some of the quotations from these interviews are listed below:

"I'm now walking again and I thought I never would. I can now get my horses back from the Mendips though the family now do the riding, but it's great to be able to go back to my stables"

"They've been very supportive and as I'm out doors normally this really matters to me. I've had a bad time and it's been really difficult, but now every day is a good thing"

"They have explained things to me very well and some people might not be able to follow them but they did not patronise me at all. They were very attentive to me when telling me"

"They have respected the house and our family life. I was impressed how they did hand washing and used special towels and kept very clean at all times"

"It would be good to see the same person and the timings are very irregular they might be much later than on a previous call….but the treatment is very good. The weekend times are not so good"

"I feel that I have been helped as a whole person to recover. I was very depressed and now I'm very much more confident and positive"

"Apart from the shock of having a heart attack, the care has been exemplary and I feel privileged to have this team helping me"

"They are respectful and the care is done with dignity and privacy. They are considerate in my house."

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider must ensure that patients receive a thorough and timely assessment that includes essential observations and risk assessments that are necessary to detect deterioration in patients' health and wellbeing.
- The provider must deploy sufficient staff to meet the demand in the district nursing service
- The provider must ensure that a safe protocol for lone working at night time is actioned and embedded and audited regularly
- The provider must ensure that record keeping is of a consistently safe standard
- The provider should review best practice in relation to recordings of wound assessments and ensure that this is embedded within wound care in the district nursing service
- The provider should ensure that essential patient information stored using the electronic record keeping system is accessible to workers when visiting patients
- The provider should ensure that medicines and dressings are stored in accordance with manufacturers' instructions
- The provider should ensure that the minimum level of training for safeguarding children for staff in the community services is compliant with intercollegiate guidelines from the Royal College of Paediatrics and Child Health in March 2014.
- The provider should use an outcome measure to facilitate benchmarking of performance of the district nursing service and independent rehabilitation teams
- The provider should encourage involvement of patients in the planning and design of service delivery in the district nursing service and independent rehabilitation teams.
- The provider should consider ways to reduce the waiting times for patients requiring non-urgent assessments and treatment. This should include review of the resources allocated to complete continuing health care and funded nursing care reviews.

Somerset Partnership NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The duplication of record keeping in paper and electronic formats led to omissions of important information essential for safe patient care. Nurses did not consistently complete baseline observations and clinical risk assessments relating to nutrition, pressure care and falls. There was a risk that deterioration in a patient's skin might not be noticed because nurses did not use photography or tracing to record changes in the appearance of wounds.

Staff shortages placed excessive strain on the district nursing workforce. Managers did not use a staffing tool and so did not have a clear oversight of when staffing levels were not safe. Investigation of incidents was thorough but some staff reported a lack of feedback from incidents, and sharing of learning beyond affected teams was not consistently widespread. Nursing equipment in syringe driver sets and bladder wash bags were past the expiry date, which meant the sterility of these items could not be assured. Variations in compliance with mandatory training meant some staff might not have been up-to-date with essential knowledge and skills to keep patients safe.

Uptake of safeguarding training was varied and the level of training for safeguarding children was below recommended guidelines. However, staff knew how to raise a safeguarding concern.

Safety performance

- Staff were unaware of their performance with regard to safety at a local level or trust-wide level. Staff were unaware of their team's performance against safety goals. Managers were not using safety performance data effectively as a 'live' tool to educate staff and this could lead to missed opportunities to improve safety for patients.
- When we spoke with district nursing staff, they told us they were unaware of a dip in safety performance as measured by the safety thermometer. Data relating specifically to the community health services for adults identified a decline in safety in May 2015, with nine new pressure ulcers equating to a prevalence rate of 1.5%, 20 falls with harm equating to a prevalence rate of 3.4%, and nine new catheter-acquired urinary tract infections equating to a prevalence rate of 1.5%.

Inadequate

Are services safe?

- Safety performance in the community health services for adults' teams was measured using the safety thermometer. Safety thermometer data, specific to community health services for adults beyond May 2015, was not available during our inspection.
- There had been 35 incidents classified as serious from June 2014 to July 2015; 94.3% of these related to pressure sores of grade 3 and 4. The trust quality improvement plan aimed to create a 'zero tolerance' culture to avoidable pressure ulcers by 2018.
- Staff were aware of safety alerts. These were communicated through a central system and shared at monthly therapy team meetings.

Incident reporting, learning and improvement

- The mechanisms to report incidents in community health services for adults were accessible because administrators in the district nursing teams had been trained to enter incidents on the system. This meant staff could phone details directly to them for system input while still in the patient's home. This change was introduced following a focus on reporting pressure damage at grade 2 and above.
- Staff told us they understood their responsibilities to raise concerns and report safety incidents. Therapists were less likely to report incidents than nursing staff. In the 12 months before our inspection, there were 1,314 incidents reported in the district nursing service. Fifty-two incidents were reported in the therapy service, 25 of which were reported by the speech and language therapy team in relation to inpatient care that this team had provided in the acute hospitals.
- Managers made relevant staff aware of incidents and thorough investigations took place. Once reported, all incidents were reviewed by the lead district nurse who decided if they needed further investigation. Incidents that met the 'serious incident' criteria were allocated an investigator by the trust risk management team. All serious incidents were monitored through the serious incident review group. All other significant incidents are monitored by Operational incident group. Monitoring of trends takes place at Clinical Governance Group meetings. The lead district nurse sent acknowledgements to staff thanking them for reporting incidents.
- Some lessons were learnt following incidents, but this was not consistent. The extent of learning beyond the affected team was varied and not reliably assured. This meant that opportunities to improve safety for patients might have been missed. Incident feedback was discussed at team meetings and at the countywide district nurse best practice group meetings. In theory, this allowed learning across areas, but this was dependent on team leaders either attending or feeding back to their teams. In July and August 2015, specific learning from incidents did not feature in the minutes of district nurse best practice meetings.
- Some staff were able to describe incidents that had led to county-wide changes in practice, such as the creation of an out-of-hours role to co-ordinate and support staff until 10 pm. In the diabetic retinopathy screening service, a thorough investigation had followed a serious incident and resulted in learning at a local and national level. Actions to resolve any undetected risk included the recalling of 450 patients who had not been seen for screening in hospital in the previous12 months. Learning from investigations of pressure ulcer incidents had highlighted the need for staff training around documentation, and this had been carried out by the tissue viability nurse.
- Sharing of learning beyond the affected team was not consistently widespread Staff reported that changes in practice had taken place without any explanation for the change, such as intravenous drugs now requiring two nurses to administer. Some staff informed us they were not aware of any learning as a result of incidents they had reported. Some teams reported incidents but did not receive feedback. The speech and language therapists we interviewed were not aware of feedback from the 25 incidents they had reported.
- In one team, therapy staff said they felt there was little point in raising a concern because nothing could be done as most incidents related to staffing issues. Staff talked through concerns between themselves but did not escalate through a formal process. Staff gave an example of an incident that occurred involving a delay in communication from a GP. They had not reported this incident because they did not want to damage the relationship with the GP.
- According to the staff survey of 2014, 21.5% of staff in community health services for adults had witnessed potentially harmful errors, near misses or incidents in the previous month, but none of those staff had reported the errors. Nurses in two different locations told us no action took place as a result of reporting

staffing-related incidents so they no longer reported them unless the situation was extremely unsafe. In the overnight nursing team, it was acknowledged by the service manager that staff were unlikely to report incidents related to a shortage of staff, even when this compromised staff safety, for example, when a band 6 nurse was working alone for an overnight shift because a band 2 nurse was not on duty. The service manager and staff told us several incidents had taken place in the overnight nursing team relating to substandard information received for referrals from the non-emergency helpline service that co-ordinated overnight referrals. Not all of these were reported on the electronic incident reporting system

- The need to increase reporting of incidents was itemised on the district nursing continuous quality improvement action plan. This included a need to identify the reasons staff did not report incidents, a review of the areas of low reporting, and ways to improve feedback. There was no target date for implementation of these actions and no progress recorded. However, there was a trust wide plan to increase reporting across the trust.
- Staff awareness of the duty of candour was variable. We asked eight members of staff in four locations about their understanding of the duty of candour – six were unfamiliar with the concept. Staff understood the need to be open with patients in the event of an incident, for example, the development of a pressure ulcer. Staff in the orthopaedic assessment service gave an example of how a complaint had been dealt with, including telephoning the complainant to gain further understanding of the incident and to offer apologies.

Safeguarding

- The level of training for safeguarding children was insufficient for the staff in community health services for adults. In the community nursing teams, independent rehabilitation teams, and specialist countywide teams, staff had completed level one safeguarding awareness training for children. This was not in accordance with guidelines published by the Royal College of Paediatrics and Child Health in March 2014. These recommended level two as the minimum level required for non-clinical and clinical staff with some degree of contact with children and young people and/or parents/carers.
- For safeguarding children training, again the compliance was varied: phlebotomy at 55.6%, Taunton independent rehabilitation team at 55.6%, Chard Crewkerne and Ilminster district nursing at 64.5%, safeguarding team at 71.4%, Taunton district nursing and South Somerset district nursing at 78.3%, North Sedgmoor district nursing at 79.2%, leg ulcer service at 80%, Primary Link at 81.8%, Mendip independent rehabilitation team at 83.3%. Some teams declared 100% compliance with this training, including West Somerset independent rehabilitation team, tissue viability, talking therapies, stroke services, South Somerset independent rehabilitation team, musculoskeletal interface, cardiac rehabilitation, Central Mendip district nursing, diabetic retinopathy, continence, community matrons and telehealth.
- Nursing and therapy staff in community teams completed safeguarding adults level one training. This training was refreshed every three years. Compliance with safeguarding adults training was varied between teams: phlebotomy 55.6%, East Mendip district nursing 63%, tissue viability 66,7%West Mendip district nursing 68.2% team, safeguarding team 71.4%, Primary Link 72.7%, West Somerset independent rehabilitation team 75%; Taunton independent rehabilitation team 77.8%, Mendip independent living team 83.3%, Chard Crewkerne and Ilminster district nursing 83.9%, and district nursing waking nights 84.6% other teams such as talking therapies, diabetic retinopathy, musculoskeletal interface, continence and community matrons and telehealth all reported 100% compliance with safeguarding adults training.
- All staff we spoke with were aware of the processes to follow in the event of a concern with either a child or a vulnerable adult, and understood their responsibilities to follow safeguarding policies and procedures. There was a safeguarding phone number on the back of each member of staff's identity badge. One team gave an example of staff identifying children at risk as a result of finding their parents and grandparent under the influence of alcohol. Another team had raised a safeguarding incident with the Care Quality Commission when they had been dissatisfied with the local authority response to their concerns. Some incident reports included reference to safeguarding concerns raised.

Medicines

Inadequate

Are services safe?

- On visits, we saw that district nurses checked patients' medicines and explained their purpose to patients and their relatives. Nurses spoke with patients to explain how to store medicines safely at home.
- Arrangements for storing medicines were not consistent. In one nursing hub, we saw medicines were being stored in a locked filing cupboard that could not be secured to the wall due to instability of the wall structure. Some dressings were stored in locked cupboards without thermometers. These dressings had to be stored below 25 degrees centigrade. At two locations, the team leader confirmed the temperature was warm inside these cupboards. Nurses stored adrenaline in their car, with no regular audit of expiry dates.
- Stocks of medicines kept at the district nurses' office were minimal, with patients' medicines being accessed by prescription from their doctor.

Environment and equipment

- District nurses used equipment contained in portable boxes to set up and operate syringe drivers. These machines enabled pain relief medicine to be administered to patients continuously in their own home. Several items of the equipment contained in four of the syringe driver sets in two locations were past their expiry date. We saw bladder wash sets that were past their expiry date. Because these items were past their expiry date, they could not be guaranteed to be sterile and if used would pose a risk of infection to patients. However, staff assured us that they would always check the expiry dates of equipment before using it.
- Patient-led assessments of the care environment (PLACE) surveys had been completed at several outpatient departments including Crewkerne, Shepton Mallet, Bridgwater, Dene Barton, Burnham on Sea, Frome, Wellington, Chard and Minehead. All actions from these had been completed except for the relocation of the hospital sign at Crewkerne Hospital.
- We saw evidence the trust had a system for tracing, locating, cleaning and servicing the nursing equipment. District nurse teams carried a bag of equipment with them for routine daily tasks. All equipment was serviced and maintained by the trust. Nursing staff were responsible for the cleaning of equipment held in their car and were required to sign a decontamination form to confirm this had been completed. Equipment in the diabetic retinopathy clinic was cleaned after use and records were kept of the cleaning procedures completed at the end of each clinic.
- Dressings and wound equipment was disposable and clinical waste systems were used appropriately. For patients with long-term treatment, we saw there were systems in place to ensure safe disposal of clinical waste.
- The trust outsourced its medical devices maintenance and management to a local acute trust. Therapy staff reported good access to assistive equipment for staff, which was provided by a private company and available within 24 hours for urgent needs. Bariatric equipment was available.

Quality of records

- The record-keeping practices of the district nursing teams were not adequate to keep people safe because their records were not accurate or complete.
- There were two record-keeping systems in operation. Nursing staff completed paper records in patients' homes and then duplicated them on the electronic record-keeping system back at base. Neither system could be relied on as a complete patient record. There was no recording system that allowed all contributors to maintain one patient record. Therefore, there was duplication of records and each system held different records of care according to who was entering the record. We reviewed 31 sets of patient records. 71% of these records contained significant omissions of more than one of the essential risk assessments. A further 10% lacked one assessment.
- The paper records we reviewed were not consistently written in a way that keeps people safe. Baseline assessments and reviews were not consistently recorded. For wound care, body maps had been completed but there was insufficient detail to allow comparison, and subsequent mapping did not occur. Often the initial assessment documents were only partially completed, which meant records did not communicate a full understanding of the patient's needs. Discharge plans were not consistently evident.
- The electronic records we reviewed were not completed in a consistent or clear way. Changes to the presentation of a patient or changes to their care plan were not easily identifiable. District nursing staff told us they were

unaware how to use the assessment templates on the electronic record-keeping system and so assessments or changes to the patient's care plan were described as a narrative in the progress notes.

- Poor record-keeping practices were having an effect on staff because they were worried continuity of patient care would suffer due to inadequate documentation. Staff did not have time to complete both paper and electronic records thoroughly and many staff completed their record keeping at home, in their own time. District nurses and their team managers consistently told us they were aware of omissions in record keeping and that workload had affected the quality of documentation. In August 2015, two incident reports referred specifically to staff being unable to complete patient documentation due to workload pressures.
- Audit of record keeping was not taking place in a systematic way across the district nursing service. Managers relied on the root cause analysis resulting from serious incidents to gain insight into the quality of record keeping. District nurses were unaware of any agreed expectations regarding the documentation that should be included in each format of records, although team managers we spoke with confirmed records should contain the same level of detail in each format.
- In January 2015, the trust completed an audit in the Wells community nursing team that focused on the documentation of catheter care plans on the electronic record-keeping system and on paper records in the patient's home. The service achieved 80% compliance in recording of catheter problems on the electronic record-keeping system and 85% of identified problem were reviewed at the time stated. In 70% of records reviewed, the paper copy of the care plan had been updated with the most current information.
- District nursing leads were responsible for monitoring record keeping practice. Action plans related to record keeping were not known by deputy divisional managers or team managers. This meant that the risks to patient safety resulting from poor record keeping were not being addressed by the teams in a cohesive way.
- The trust did not categorise the electronic record-keeping system as a 'risk' at divisional or corporate level. However, it was recognised in the district nursing service continuous quality improvement plan that recording on the electronic record-keeping system did not reflect the complexity of needs of patients and did not easily support personalised care planning. This quality improvement plan identified two actions: that a risk assessment was required and that the electronic record-keeping system needed to be 'live'. No progress had been made with these actions other than a meeting had been requested with the clinical commissioning group. The duplication of records in paper and electronic formats was also itemised as an issue to address, and the trust agreed 'to work with the clinical commissioning group on a single care plan'. The target date for this was December 2015 and no progress was recorded. The district nursing service was working towards implementing the electronic record keeping system as the primary record however with limited access to the 'live' interface and the need for patients, families and other providers to contribute to the assessment/care plan this was a work in progress. The clinical commissioning group were working with all providers regarding people with long term conditions and personalised care planning as part of the Five Year Forward View.
- Record keeping in the therapy teams did not consistently include reference to patients' goals for treatment. This omission was evident in eight of the twelve sets of patient records we reviewed. This meant that there was a risk that patients had not been consulted as part of the goal planning process and that subsequent reviews might not consider the patients progress against their original goals.

Cleanliness, infection control and hygiene

- A trust audit of infection prevention and control took place in May 2015 at Shepton Mallet Hospital outpatient department, scoring 98%, and at Burnham on Sea Hospital outpatient department in April 2015, also scoring 98%. In some teams, a healthcare assistant was responsible for asking staff if hand hygiene precautions had been used, and self-reported hand hygiene audits were completed in the overnight nursing team.
- Patients recently discharged from the services were complimentary of how staff ensured hygiene with wounds and general cleanliness. One carer remarked: "They've been very respectful in the house and they take their shoes off and clean everything and they pack it all away tidy and keep clean and always look smart. This all reassures us…this makes me very much more at ease."

Inadequate

Are services safe?

- During our inspection, we observed that nursing and therapy staff usually followed infection control guidelines, but this was not consistently evident. During three consultations we observed, therapy staff did not wash their hands before or after their contact with the patient.

Mandatory training

- The South Somerset Community Health service was below target for mandatory training, with compliance below 90% for basic life support, safeguarding, information governance, consent, dementia awareness, moving and handling, and fire. The Bridgwater, North Sedgemoor and West Somerset Community health service was below target for mandatory training, with compliance below 90% for conflict resolution, infection control, information governance, consent, dementia awareness, and moving and handling. Compliance with Fire safety training was only 78.2%. Mendip community health services were below target for compliance with mandatory training, with compliance below 90% for clinical risk assessment and management, safeguarding level 1 and 2, and fire safety. Compliance with training for consent was at 84.7%, dementia awareness was 83%, moving and handling at 80.1%, conflict resolution at 83.8%, and safeguarding adults level A at 84.5%.
- In the trust-wide staff survey, only 65% of staff reported having health and safety training in the past 12 months, which was 8% lower than the national average.
- The annual report of the regulation and governance group identified that the trust did not have a consistent approach to manual handling training and a risk assessment was to be carried out as part of the training needs analysis. Uptake of moving and handling level two training, which included risk assessor training, was varied with several teams reporting low compliance rates. These included podiatry at 28.6%, tissue viability at 66.7%, Taunton district nursing team at 69.5%, leg ulcer team at 73.3%, South Somerset district nursing team at 75.4% and West Mendip district nursing team at 81.8%. West Somerset, North Sedgemoor and Chard/ Crewkerne and Ilminster district nursing teams all reported below 90% compliance. Compliance in stroke services, musculoskeletal physiotherapy, community matrons and telehealth, and the Central Mendip district nursing team all reported 100% compliance. Staff were observed in treatment sessions to demonstrate competent moving and handling techniques.
- Staffing issues had affected compliance with mandatory training, two members of staff told us they had training sessions cancelled due to workload issues, for example, too many visits and not enough staff. Some staff completed online mandatory training in their own time. Poor compliance with mandatory training and inability to release staff to attend training had been on the divisional risk register in South Somerset as a high risk. Mitigation was dependent on staff checking their individual learning record and managers reminding them to book onto training.

Assessing and responding to patient risk

- We reviewed patient records and found that comprehensive risk assessments were not consistently carried out for patients using community health services for adults. Essential risk assessments related to pressure care, nutrition and falls were not consistently completed. Basic observations were not consistently completed or reviewed. This meant the ability of staff to identify and respond to changing risks to patients, including deteriorations in their health, may have been compromised.
- Managers confirmed all patients should have basic risk assessments completed on their first visit, including a set of basic observations, nutritional assessment using the malnutrition universal screening tool, a falls risk assessment, and risk of pressure damage assessment .
- Opportunities to minimise harm to patients were missed because nursing staff were not consistently identifying patients at risk of pressure damage to their skin. The pressure ulceration policy specified that a waterlow assessment tool should be completed on the initial visit in order to ascertain the risk of pressure damage to the individual patient. When serious incidents of pressure ulcers were reviewed; investigations had shown that waterlow assessments were not consistently completed. Patient records examined during our inspection confirmed that waterlow assessments were not consistently completed or reviewed in a timely way.
- Opportunities to minimise harm to patients were missed because records showed that nursing staff were

not consistently identifying patients at risk of falls. This meant frail patients living in the community may have been frequently falling or at risk of falls and would not have been identified as needing treatment. Untreated falls have the potential to seriously reduce the independence of older people, and can also be symptomatic of serious health concerns.

- An integrated risk assessment tool was available to manage risk of falls in community settings. We observed therapists completing this assessment and this was seen in the patient records. Team managers reported that nursing teams were unlikely to complete the falls risk assessment tool. Our review of records confirmed this assessment was rarely completed by nursing staff. Nurses we spoke with were unaware of how to fill in or how to interpret this measure. Capacity to release staff for falls risk assessment training was reported as challenging due to competing priorities of workload.
- We looked at minutes of falls best practice group meetings and saw that falls prevention among community patients was rarely discussed, and training of district nursing teams was not mentioned. In July 2015 the falls best practice group identified the need for community staff to identify those who had fallen in the previous 12 months. The need for district nursing representation at this meeting was also acknowledged.
- The trust completed an audit of the National Institute for Health and Care Excellence (NICE) clinical guideline 161, standard 12 'identification of older patients at risk of falling', and standard 13 'completion of a falls risk assessment tool for all patients at risk of falling'. This identified areas for improvement in community practice. Recommendations included a need for increased awareness of staff working in community and outpatients settings to identify patients who had fallen in the past 12 months. The action plan from this audit recommended a full policy review, an updated training plan, the setting up of a falls care plan library and a further re-audit in 12 months' time.
- We looked in patient records and saw that opportunities to minimise harm to patients were missed because nurses and therapists were not consistently completing malnutrition screening assessments. This meant frail people living in the community were at risk of malnutrition as changes to their weight might have gone undetected.
- Nursing team managers reported that malnutrition universal screening tool scores were likely to be omitted. This had not been routinely audited. Our review of nursing records confirmed that this tool was not consistently completed or reviewed regularly. One team leader said nurses did not know how to interpret the scores on the nutritional assessment tool.
- We looked in patient records and saw that opportunities to minimise harm to patients were missed because wounds were not consistently assessed and reviewed in a thorough way in accordance with the trust wound management policy. This stipulated every patient with a wound be required to have a wound assessment completed at the first dressing change. For patients with a pressure ulcer, a full holistic assessment was required to be completed within one week of acceptance onto a community caseload. All wounds were to be evaluated and documented at each dressing change.
- The need for staff to complete more thorough wound assessments, including dimensions of wounds, was identified in three investigations into serious incidents (6 January 2015, 4 February 2015, and 31 March 2015). Our review of records confirmed that neither holistic assessments nor wound mapping were consistently or thoroughly completed.
- Nurses acknowledged their method of recording of wounds did not enable accurate monitoring of progression or deterioration of a wound. The National Institute for Health and Care Excellence (NICE) guidelines recommend use of a validated measurement tool such as photography or transparency tracing when assessing wounds. This is because repeat views of a wound can be compared objectively over time**.** The use of photography to assess wounds was discussed at the best practice group over the three years before our inspection but implementation had been stalled due to information governance concerns. There was no awareness in frontline teams of progress with this issue.
- District nurse teams were aware of 'do not attempt resuscitation' decisions made by a patient. The documented decisions were held in the patient's home. These decisions were also recorded in the district nurses' office.

Staffing levels and caseload

- The district nursing service consisted of locality hubs and spokes, which housed teams of healthcare assistants, band 5 and band 6 nurses, who were managed by a band 7 nurse. The service provided cover

24 hours a day, seven days a week, across the county. There were eight different shifts covered by the district nursing teams. The twilight shift was from 5pm to 10 pm and overnight district nursing cover was available 9.45pm to 8.15am. The overnight nursing cover was organised in three teams, each team covering one third of the county and consisting of one healthcare assistant and one band 6 nurse.

- Staffing levels were not planned using a robust method that ensured patients received safe care and treatment at all times. We were told that staffing levels were based on experience and clinical knowledge but no national tool was used to support this expert local knowledge in either the district nursing or the independent rehabilitation teams. The district nursing service capacity review stated that the introduction of a tool had been deferred due to the pressures of staffing within the service.
- Deputy divisional managers confirmed that their system for identifying risk associated with capacity issues relied upon staff informing them that they were no longer able to cope with the demand. On the divisional risk registers, the mitigating plan was for the risk to be escalated to divisional managers if any federation fell below staffing establishment for more than five days. We saw that staff were feeling overwhelmed with the pressure of meeting the needs of patients. The district nursing capacity review concluded that the district nursing caseload was full and a protocol for closing caseloads was urgently required. This was also identified in the district nursing quality improvement plan. At the time of our inspection this protocol was still under development.
- There was not a robust system available to review staffing levels. Although the trust was investigating options for use of a staffing tool, at the time of our inspection there the community health services for adults did not use a dependency or acuity tool to calculate safe staffing levels in the district nursing teams and no measures had been used to assess if sufficient staff were available to meet patients needs.. Staffing levels had not increased at the same rate as the activity levels.
- In September 2014, there were 225.2 whole time equivalent registered nurses and 50.2 health care assistants in the district nursing service. In September 2015, there were 232.6 whole time equivalent registered nurses and 52.3 healthcare assistants working in the district nursing service. This equated to an increase of 3.6 %.
- Activity levels for the district nursing service had risen. The district nursing service undertook 84,645 appointments during the period from 1 April 2015 to 30 June 2015. This was an increase of 6,871 or 8.8% compared to the same quarter in the previous year. In March 2014, the number of face-to-face contact visits completed by the district nursing service (excluding ambulatory care clinic contacts) was 23,538. In August 2015 this figure was 25,719. There had been peaks in delivery in October 2014, January 2015, March 2015 and June 2015 when visit totals were over 27,000 with the highest recording in July 2015 when 28,164 visits were completed.
- Actual staffing for the overnight nursing shift was sometimes less than planned staffing levels. This meant that the lone working protocol for twilight and overnight nursing shifts was not consistently adhered to. We checked the duty rosters for the overnight shifts in July, August and September 2015. In the Mendip overnight nursing team, there was just one trained nurse on duty on 20 July 2015, 26 July 2015, 27 July 2015, 22 August 2015, 10 September 2015, 15 September 2015. In the Bridgwater Bay and Taunton overnight nursing team, there was one healthcare assistant on duty with no registered nurse on 4 August 2015 and 01 September 2015. There was one registered nurse on duty in this team on 01 August 2015, 02 August 2015, 09 August 2015, 10 August 2015, 11 August 2015, 21 August 2015, 22 August 2015. This meant that on the 22 August both the Bridgwater Bay and Taunton overnight nursing team and the Mendip overnight nursing team were covered by one nurse in each geographical area. In the South Somerset overnight nursing team, there was one healthcare assistant with no registered nurse cover on 26 August 2015 and 27 August 2015.. The expectation was that staff attended visits in pairs when working on the overnight nursing shifts and for the twilight shift, managers preferred staff to work in pairs but were agreeable to staff making scheduled routine visits to patients during the summer months.. An incident report detailed a situation where a nurse was the only nurse on duty for the twilight shift in her locality team. They were called to visit a new care patient who required urgent

palliative care, they could not find the address, they had no mobile phone signal and the relative was distressed and had been drinking alcohol. This nurse was required to complete heavy moving and handling alone.

- High sickness rates resulted in actual staffing levels being less than the planned staffing levels and this impacted upon the capacity of the teams to cover shifts. In March 2015, the trust overall sickness rate was 4.92%. Sickness rates within the community health services for adults varied, with West Somerset adult rehabilitation service having the highest rate at 9.42% and the Mendip adult rehabilitation service having a rate of 1.16%. Sickness rates in the district nursing teams were at 6.12%. In January 2015, South Somerset district nursing team had five members of staff on long term sick leave. Sickness within teams caused high levels of stress amongst staff as evidenced in incident reports. One of these incident reports cited unsafe staffing levels due to prolonged staff sickness in one district nursing team, with a deficit of 60 hours per week of community staff nurses since 20 July 2015, and 30 hours per week from the 15th June 2015.
- The federation model allowed flexibility to manage sickness absence within each locality and the hub coordinator role enabled visits to be allocated centrally at the point of triage.
- Incident reports indicated that many staff was being asked to work extra hours at short notice in order to cover shifts. The day before our visit one nurse reported that she was on duty from 9am until 10pm to cover sickness absence.
- The Annual Health and Safety Report, presented to the Integrated Governance Committee, identified that there was insufficient capacity within the staff occupational health Well@Work service to accommodate the stress management needs of staff. In the trust wide staff survey, the score for work pressure felt by staff was 3.15 out of a possible 5, this is 0.08 higher than the national average. In the staff survey of 2014, an average of 75% of staff working in adult community health services reported working extra hours.
- Vacancy rates affected the capacity of some teams. The Burnham on Sea district nursing team had a vacancy rate of 4% that was forecast to rise to 22 % in November 2015 as they had not succeeded in filling vacancies. There was a 12.2% vacancy rate for band 8 posts. Actual whole time equivalent staffing levels were below the agreed establishment in all district nursing teams. South Somerset team had 55 whole time equivalent staff against an agreed establishment of 59.9; Chard, Crewkerne and Ilminster team had 27.3 whole time equivalent against an agreed establishment of 31.2, North Sedgemoor had 21.2 whole time equivalent staff against an establishment of 23.9, and the Taunton team had 47.9 whole time equivalent staff against an agreed establishment of 50. Teams at Bridgwater and West Somerset were 0.5 whole time equivalent down on their agreed establishment. The overnight nursing team had 12.3 whole time equivalent staff against an agreed establishment of 13.7.
- High staff turnover and delays in recruitment affected the capacity of some teams. Trust wide, the percentage staff turnover was 14.2%. Some independent rehabilitation teams reported high turnover of staff in the 12 months prior to our inspection, with South Somerset at 32.7%; Taunton at 29% and Mendip at 21.4%. The bowel and bladder service reported a 50% turnover of staff during the same period. Delays in recruitment occurred because all vacancies had to be approved by the executive management team who met every two weeks. Available funding could not be converted to facilitate recruitment until implementation of integration phase two was completed. The date of this was not known.
- Over the four weeks prior to our inspection, bank or agency staffing had been used in 10 of the 12 teams to mitigate the risks of understaffing. The percentage of the establishment staffing as bank or agency staff was low in some teams, i.e. 0% in Sedgemoor rehabilitation team and Crewkerne, Ilminster and Chard district nursing team, but high in Mendip rehabilitation team at 15.6%, South Somerset rehabilitation team 14.1%, West Somerset rehabilitation 10.7% and North Sedgemoor district nursing team at 8.9%. The overarching safer staffing action plan dated August 2015 highlighted the need for recruitment of bank workers to increase supply. Progress against this action was not recorded.
- Capacity of the district nursing teams was stretched to cover 'timed visits' which were perceived to be increasing. Some patients living with diabetes needed district nurses to visit at a regular time early morning in order to check blood sugar levels and to administer insulin as required. It was acknowledged amongst frontline and managerial staff that there had been an increase in the number of these visits. One incident

report described a situation in one location where a team of three nurses were required to complete seven timed insulin injections and attend to two complex patients before 9 a.m. As no extra cover was available to cover the six timed visits between 4pm and 5pm, the same team were required to work extra hours to meet the needs of these patients. Nurses expressed concern that patients requiring insulin were sometimes required to wait for their injection longer than the agreed time, putting them at risk of hyperglycaemia. However there were no incidents reported of this within the 12 months prior to our inspection. Some teams had rearranged the timing of these visits to allow for a staggered completion. This impacted upon patients and the management of their condition as they were required to wait longer before they could eat breakfast.

- The administration of insulin in community settings was on the divisional risk register for West Somerset as high risk since April 2011. Mitigating actions had included the establishment of an insulin register to reduce risk of errors or omissions of administration. The trust had not undertaken any audit of the frequency of these 'timed visits' but the need for a countywide review of the increasing number of timed visits was itemised in the continuous quality improvement plan. No progress with this had been recorded.
- The impact of workload pressures was evident in the incident reports completed over the 12 months prior to our inspection. In the past 12 months, there were 31 staffing related incidents reported. Thirteen of those reported referred to the negative impact on the health and wellbeing of staff. Ten reports referred to patient visits being deferred or delayed. One of these included a patient who had waited 4 hours for a nurse to visit to assist with a blocked catheter. Another of these visits was reallocated to the GP team as there were insufficient nurses to visit a high risk patient in pairs. Two incidents specifically mentioned continuing healthcare and funded nursing care assessments that were deferred when band 6 staff were required to cover visits for critical patients. Two incidents reported complaints regarding delays in answering the hub telephone because the registered nurse had been required to cover visits rather than cover the coordinator role. Two reports referred to documentation not being completed.
- One team manager admitted that her team felt unable to provide the quality of care needed for end of life patients due to a pressure of workload. One incident described how a patient's family had contacted the non-emergency helpline service requesting an urgent district nursing visit for end of life care. The nurse was working alone during the twilight shift and had not been able to reach the patient before they passed away.
- A senior member of staff told us that a lot of gaps in the community nursing rotas were filled by their own staff 'good will' to make sure patients' needs were met. Several community staff told us they recorded the outcomes to their visits in their own time as they could not fit it into their working day. This was evident in two incident reports. One staff member told us she had used her annual leave to complete her paperwork. One team had nearly 50 hours of time owing to them as a team but were still asked to help to cover other teams work.
- District nurses reported that the number of visits they completed had increased from approximately nine visits to 11-15 visits per shift. The district nursing capacity review confirmed that this was an increasing occurrence within the district nursing service. Data regarding the number of visits completed by each nurse on each shift for the past 4 weeks was supplied by the trust but was later deemed inaccurate. Subsequent attempts to gain accurate data from the trust were not successful.
- Divisional management identified staffing as the biggest risk to the community health services for adults. The staffing risks in the district nursing service had been identified on the divisional risk register at Bridgwater and South Somerset with potential implications for patients, staff and the trust. At a recent district nurse operational group meeting, band 7 representatives from all the hubs raised staffing concerns including staff being unable to take breaks, managers covering clinical shifts to ensure cover, lack of administration cover, difficulty accommodating timed visits due to lack of staff.
- At a corporate level, the pressures in district nursing were identified as high risk on the risk register. The controls in place included the establishment of the continuing healthcare assessment teams and the use of the electronic record keeping system to manage capacity. Neither of these controls was making a real difference to the risk on the frontline. Actions planned to mitigate the risk were focussed on the implementation of integration phase two which had not commenced.
- In January 2014, a holding paper was presented to the trust board and agreement was reached to focus

discussions with the clinical commissioning group regarding the future working models and financial viability of the district nursing service. A continuous quality improvement action plan for district nursing, dated August 2015, identified key concerns in relation to staffing in the district nursing service that were highlighted in our inspection, specifically that capacity did not meet demand, increasing complexity of patient's needs, increasing number of timed visits and increasing care management responsibilities.

- The continuous quality improvement plan for district nursing identified the need for several actions. Firstly: a capacity and demand review; this had been drafted and was awaiting submission to the clinical commissioning group. This review compared the whole time equivalent staffing levels of the trust with the national average and concluded that the trust had a deficit of 49.7 whole time equivalent staff. Secondly, the plan identified the need for the development of a dependency tool; a meeting with the clinical commissioning group was to be arranged to discuss the implementation of a tool that had been developed. Thirdly, the plan identified the need for parameters to be set with the clinical commissioning group; progress with this action was awaiting the outcome of the quality contract meeting. Other actions included to ensure that incidents related to staffing were recorded on the electronic incident reporting system, to establish safer staffing levels and lastly, to ensure the emotional health and wellbeing of staff was a priority.
- Staffing pressures in the independent rehabilitation teams were less evident. There had been no incidents reported related to therapy staffing in the 12 months prior to our inspection. In physiotherapy, we were told that earlier this year there had been nine vacancies from a total of 70 whole time equivalent staff, with a 30% rise in referrals since 2008 for which the service had received further funding to increase the establishment to meet the increased demand. Staffing in podiatry and diabetes service had also been raised as a risk at divisional level in Mendip with impact upon patient waiting times.

Managing anticipated risks

- Staff were not aware of an action plan to mitigate the potential risks of adverse weather during winter 2015. Planning for the impact of fluctuations in demand over winter had not yet involved community nursing or district nursing teams. No funding for winter mitigation measures had been allocated to the trust for winter 2015.
- During the winter prior to our inspection, the community health services were involved in several innovative projects to reduce pressure on acute beds and make care available for patients being looked after at home. For example, Taunton rapid access care co-ordination, which aimed to discharge patients early from acute hospital beds, providing ongoing care in the community. The acute trust was in the process of evaluating this project from the perspective of the patient pathway to determine the number of admissions avoided. Also, the district nursing service employed healthcare assistants to provide a night sitting service to prevent hospital admission.

Major incident awareness and training

- Following major flooding in December 2013, the trust reviewed their response to major incidents in January 2014. Several actions were identified but no update from the trust was available.
- Staff were clear that should the weather affect their ability to access rural areas, prioritisation of the most vulnerable patients took place. A list of 'at risk' patients was held on the electronic record keeping system. Access to a 4x4 off road transport was available and district nurse hubs and offices had a plan of action.

Requires improvement

Are services effective?

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

Summary

Staff working in patient's homes frequently had no access to wireless internet or mobile phone signal and this meant they did not have essential information needed to deliver effective care. Although staff had good access to training, the systems to ensure that staff had the right skills and knowledge to do their job on an ongoing basis were not reliable because there was mixed compliance with appraisals and there was a lack of consistent approach to the supervision of staff. Multidisciplinary working needed improvement because the arrangements for delivering care for complex patients did not always involve all the teams in a coordinated way. . At the time of our inspection, district nurses, therapists and doctors did not meet formally to proactively prevent deterioration in patients at risk in the community. District nurses and therapists in the independent rehabilitation teams did not write discharge summaries to inform GP's of the outcomes of treatment. However, we saw some good examples of multidisciplinary working within specialist teams.

In the district nursing and independent rehabilitation teams, no outcome measures were used to benchmark the performance of the service. This meant that teams did not know how effective their care was in comparison to other similar services. Therapists used individual outcome measures to monitor patient's progress. Patient reported experience measures were used in some services such as musculoskeletal physiotherapy and the orthopaedic assessment service. Compliance assessments for NICE guidelines had been completed for most relevant quality standards. There was evidenced-based practice within some specialist county-wide services such as diabetes and the stroke early supported discharge team used outcome measures to benchmark the effectiveness of this service. Patients using telehealth acquired confidence and reassurance from the service which enabled them to manage their long term conditions more independently.

Detailed findings

Evidence based care and treatment

- Care and treatment was provided in line with national best practice guidance including National Institute of Health and Care Excellence (NICE) quality standards. Compliance assessments had been undertaken for a number of NICE quality standards which demonstrated that the trust was fully compliant with guidelines. These included: the assessment and prevention of falls in older people; Parkinson's disease diagnosis and management in primary and secondary care; pressure ulcers and Stroke rehabilitation in adults.There were three dedicated stroke teams that provided both early supported discharge and follow up specialist stroke community care throughout the county. This included joint working with the independent rehabilitation teams. There was an enhanced early supported discharge pilot for stroke patients in the Mendip area.
- The diabetic eye screening service was working to nationally set interim quality assurance standards set by the UK National Screening Committee in August 2014. The diabetic specialist service offered an accredited education programme DESMOND and participated in the dose adjustment for normal activity structured education programme hosted by the acute trust. All the nurses in the team either were accredited nurse prescribers or were working towards this qualification. The service was involved in the auditing of the use of drug therapies such as dapagliflozin and had presented their findings at the diabetes UK conference.
- Best practice groups were a forum for discussion and countywide dissemination of evidence based practice.

Pain relief

- An acute pain assessment and management tool existed but was not seen to be in use in community health services for adults. This meant that an accurate assessment of the pain experienced by the patient was not available, and treatment options to alleviate pain could not be accurately tailored to address fluctuations in pain levels. However all patients we spoke with reported that their pain had been well managed.

Requires improvement

Are services effective?

- Therapists and nurses were observed to be assessing and managing pain levels within treatment sessions, for example a district nurse planned a wound dressing change with the patient to ensure pain relief was taken prior to the visit to make the patient as comfortable as possible during the procedure. We saw that when a patient was not pain free nursing staff acted promptly and with compassion and reassurance.

Nutrition and hydration

- A trust audit of nutrition support in adults in March 2015 concluded that nutritional screening in community settings needed to improve; only 50% of patients were screened at first appointment. Repetition of this screening also needed to improve; the audit showed this occurred in 69% of patients
- In the records we reviewed, the nutrition and hydration needs of some patients had been assessed using the malnutrition universal screening tool but this was not consistently completed or reviewed. This meant that patients could not be guaranteed a holistic assessment of their needs and risk of malnutrition may not have been identified.
- However, we saw on patient visits that patients were offered drinks. One incident report described how district nursing staff attended a patient several times a day to ensure they had sufficient food and drink whilst that patient was awaiting provision of a care package.

Technology and telemedicine

- Telehealth was being used effectively to enhance treatment and to support patients to manage their care at home. The telehealth service was monitoring 248 patients with chronic obstructive airway disease and heart failure in conjunction with 69 GP practices. They were hoping to expand the service to include patients with diabetes. This service aimed to prevent hospital admission using a teleconferencing system which was available for patients to access from home. Patients used a decision tree and specific questions triggered alerts to the telehealth nurse. There was a system in place for escalation if the patient did not input data at the agreed time.

- The focus of the telehealth service was on patient outcomes and regular use of the friends and families test confirmed that the service was appreciated by patients. Of the patients who completed the friends and family test, 78% were extremely likely to recommend and 19% are likely to recommend the service. Comments from patients highlighted their feelings of increased confidence and peace of mind.

Patient outcomes

- There was not a clear systematic approach to monitoring, auditing and benchmarking the quality of the service in the district nursing or the independent rehabilitation teams. Audit reports were published on the Intranet and highlighted in the staff newsletter "What's on @ SomPar" and were shared through the Best Practice Group. However, district nurses and therapy staff working in the independent rehabilitation teams told us they were not aware of the outcomes of audits.These teams did not use data to determine the effectiveness of their treatments. Outcomes were not monitored at service level or matched with similar services to benchmark performance. However, in speech and language theapy, patient recorded outcomes were used with voice patients and within the early supported discharge team.
- No data was available to indicate the number of hospital admissions that had been avoided in the independent rehabilitation teams or district nursing service, although this was measured in the specialist admission avoidance projects. Primary link was an admission prevention service which had diverted admissions from hospitals to community based services. During the three months prior to our inspection this service had diverted 105 admissions. Spearhead was a district nurse admission prevention team in Yeovil who put together community packages of care. This team had prevented 10 admissions in the past three months
- In the independent rehabilitation teams, therapists used discipline specific outcomes measures to determine individual patient progress. We spoke with 19 patients who had recently been discharged from district nursing or independent rehabilitation services, these patients described how they had been able to reach their goals such as pursuing hobbies, walking or making a cup of tea.

- The use of patient reported experience measures was not widespread. Following participation in the national audit of intermediate care, the trust identified a need to put in place processes to improve the return numbers of

patient reported experience measures. Patient recorded experience measures were used in some services such as the orthopaedic assessment service. A patient reported experience measure was used in the musculoskeletal physiotherapy service to collect feedback from patients. Individual staff members received individual feedback on their performance using this measure. These had been developed in conjunction with patients.

- All patients seen by the stroke early supported discharge service and stroke inpatients were assessed using standardised outcome measures which were all reported on the discharge summary to clearly show evidence of patient's improvement.Goals were set using a standardised template. Data from outcome measures in the early supported discharge service were reported to the clinical commissioning group. The most recent analysis of this data was from 2013/14.
- Data from the Sentinel Stroke National Audit Programme was available for the stroke early supported discharge service and this showed a varied picture of achievement. Of the seven standards that were applicable to this service, three had maintained at the highest level of effectiveness, improvement had been achieved on one, one had maintained at the lowest level and one had deteriorated from the highest to the second highest level. This data indicated a decline in provision of occupational therapy and this was attributed to lower staffing levels. This data also identified a decline in provision of speech and language therapy and this was attributed to an increase in complexity and severity of language deficit seen in patients. The time taken for rehabilitation goals to be agreed was also highlighted as an area for improvement. Key strengths of the service were identified as quality of discharges, nutritional screening, continence plans and screening of mood and cognition.
- In the countywide services, the podiatry service had trialled a reduction in appointment times from 30 minutes to 20 minutes in an attempt to reduce waiting lists, but had reversed this directive because they felt the outcome had been a reduction in quality of treatment. The diabetic screening service monitored performance against screening targets via a weekly report and were able to use staff resources flexibly across the county to address shortfalls. Comments from patients attending the cardiac rehabilitation class were positive; referring to the confidence they had gained to enable them to manage their condition.
- The trust achieved its clinical improvement plan targets related to the friends and families test for the year 2014-2015. For 2015-16, the trust clinical improvement plan identified a commissioning for quality and innovation target for reducing avoidable hospital admissions through increased use of: ambulatory care centres for treatment of blocked urinary catheters; Intravenous therapies; peripheral inserted central catheter line management and negative pressure wound therapy;.. These centres were staffed by the district nursing service and community hospital staff. The plan also identified a commissioning for quality and innovation target for the establishment of a frailty assessment for older people. It was intended that generated scores from this tool would trigger coordinated pathways of care. No data was available to ascertain if an impact of these targets had been seen.

Competent staff

- The system to identify the learning and development needs of staff was not reliable because appraisals were not regularly completed in all of the teams in the community health services for adults.
- In the trust wide staff survey, only 34% of staff were identified as having well-structured appraisals in the last 12 months. This was 7% lower than the national average. Training in how to conduct appraisals was not mandatory for appraisers. In the community health services for adults, appraisal completion rates were variable. Data provided by the trust indicated that whilst some teams reported 100% compliance with this completion of appraisals, others were underperforming. Data for the independent rehabilitation teams was submitted as data for independent living teams, and may have included staff who at the time of the inspection were no longer under the managerial control of the trust. This data indicated that Mendip independent rehabilitation team had completed only 17% of appraisals, and Taunton independent living team had completed 50% of appraisals. The stroke team had completed 50%, and West Mendip district nursingteam had completed 55% of staff appraisals. Central Mendip and West Somerset district nursing teams had completed 67% of staff appraisals.

Requires improvement

Are services effective?

- Poor compliance with staff appraisals impacted upon staff at an individual level and trust wide level. Appraisals give protected time for personal development needs to be discussed. Following the annual round of appraisals, managers submitted the training needs of their teams, and these were collated centrally by the trust learning and development team into a training needs analysis which informed the organisation wide priorities for training.
- The arrangements for supporting staff and managing the development needs of staff were not reliable because staff supervision was inconsistent. Frequency and quality of supervision was not regularly audited. This meant that protected time for staff support was not guaranteed. The importance of clinical supervision was highlighted in a recent audit of intermediate care services the trust identified a need for regular discussion of patients and complexity mix to occur during supervision.
- The type and frequency of supervision was varied across the community health services for adults. In some specialist teams, staff received one to one supervision with their manager on a monthly basis, in others, supervision occurred in the form of a team meeting or an informal, ad hoc basis. Agreed timescales for supervision were not always adhered to, and supervision was not always recorded. One team leader told us that there was no time to do supervision. However, therapy staff told us that they felt adequately supported in their clinical practice and able to access clinical supervision from more experienced clinicians to discuss any areas of concern.
- Team mangers explained how staff performance was managed using appropriate measures. A staff member explained how she had been redeployed to a role that did not require moving and handling in order to accommodate her recovery from a musculoskeletal injury. A 'physio for you' service was available for staff. A number of staff in the community health services for adults had been supported back to work with the Well@Work team.
- Staff awareness of the needs of patients living with dementia could not be guaranteed in all of the teams in the community health services for adults. This was because attendance at dementia awareness training was varied. Several of the countywide specialist services achieved 100% compliance such as tissue viability, leg ulcer team, chronic fatigue syndrome team, cardiac rehabilitation, telehealth, community matrons, continence, musculoskeletal physiotherapy, adult speech and language therapy and the dietetic service. Others reported low compliance the worst of these being the South Somerset district nursing service at 49.3% and the stroke service at 50%. West Somerset, East Mendip, and Taunton district nursing teams and the Mendip IRT and podiatry were below 75%.
- Every healthcare assistant at band two and three was offered the opportunity to complete the assistant practitioner's course at a local college. A band 5 plus programme was available which was a competency based programme that demonstrated leadership qualities through reflection. A band 5 nurse had recently completed the Mary Secole leadership course. Another nurse told us that she was about to start an older persons degree module at university and a healthcare assistant told us she was being encouraged to attend the assistant practitioners course. In the ambulatory care clinics, nursing staff could receive training in competencies to manage intravenous therapy, peripherally inserted central catheters and central venous catheters. This training was overseen by the clinical nurse specialist from the acute trust. Staff underwent a rigorous training program to be able to do compression bandages. Some of the teams were liaising with acute oncology departments to help deliver and assess competencies for nursing.
- Therapy staff identified that they were encouraged and given opportunities to develop. All the therapists we spoke with in the independent rehabilitation teams confirmed that they were supported by their managers to attend training whenever possible. Clinical specialists were available to provide leadership around quality. Monthly continuing professional development sessions centred on topics such as amputee management.
- Staff in some of the specialist county-wide services were encouraged to participate in external training to ensure they had the right skills to do their job on an ongoing basis. For example, Band 5 staff in the diabetic eye screening service completed a city and guilds diploma in diabetic eye screening and all band 3 practitioners completed the first four units of this course. All staff in this team had a competency assessed induction programme. All graders were required to pass a national examination once per month and met with an

ophthalmologist once every two months to discuss grading reports. The diabetes link nurse attended meetings four times a year with the diabetes specialist nurses where they gained support and information and were able to discuss unusual or difficult cases. Learning was shared at team meetings.

- The splinting service ensured that all staff participating in the fabrication of thermoplastic splints were supported by more experienced clinicians until competencies were assured in accordance with the Association of Chartered Physiotherapists Interested in Neurology and the College of Occupational Therapy practice guidelines 2015.
- In the musculoskeletal service, physiotherapists participated in training events four times per year plus an annual training day with external speakers. Clinicians were allocated one and a half hours of continuing professional development time per month to focus on personal development objectives.
- All healthcare professionals working in the community health services for adults had up to date professional registration.

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary working needed improvement because the arrangements for delivering care for complex patients did not always involve all the teams in a coordinated way. District nurse teams took part in hub meetings to discuss any patients of concern, such as those at risk of hospital admission and discharges known to be taking place from hospital. However, healthcare professionals in the community health services for adults did not meet formally with their colleagues in other teams to proactively prevent deterioration in patients in the community.
- However, there were plans to address this with the implementation of a new model of multidisciplinary working called 'integration phase two'. This was a vision of an integrated healthcare approach encompassing the district nursing teams, the independent rehabilitation teams and the older people's mental health teams. It was envisaged that a weekly meeting would occur that brought together key professionals from each of these teams to discuss specific patients with complex needs and determine an assessment and escalation plan. This was not in place at the time of our visit and the timescale for its implementation was not known.
- The single point of access systems in the district nursing service and the independent rehabilitation teams were not multidisciplinary. They did not incorporate opportunities for challenge from other disciplines.
- The move to federation model of district nursing had threatened the existing relationships with GP practices. This was evident in Feedback obtained via a survey of the district nursing service in June 2015. Link nurses had been established at some GP practices to improve communication but this was not consistent. GPs attended multidisciplinary meetings at community hospital sites. Nurses attended gold standard framework meetings with GPs every six weeks. In some surgeries the district nursing rota had been adjusted to enable district nurses to access the surgery in between patient visits to collect prescriptions in person.
- Nurses had no direct telephone access to the out of hours GP, instead having to telephone the non-emergency medical helpline service and wait for a call back. This impacted upon patient care. For example, an incident report described how a district nurse had requested an urgent review of medication for a patient with end of life care needs. The nurse waited over two hours but no contact was received from the GP out of hour's service.
- Staff in nursing and therapy teams provided examples of multidisciplinary team-working with specialist services, such as the joint approach to management of a patient with a grade four pressure ulcer that required intervention from the tissue viability nurse and the social care team.
- The district nursing teams had links with the mental health teams and any concerns about patient care would be discussed with the mental health lead. Mental health teams used the same electronic patient records system. Although not all the mental health assessments and progress notes were visible to those staff working in the community health services for adults, district nurses and therapists were able to access a brief overview of the mental health needs identified.
- Several teams were working closely together to meet the specialist needs of specific patient groups. The continuing healthcare assessment team based in

Taunton shared office space with the mental health team and they felt this was conducive to information sharing and effective joined-up working. The podiatry service was working closely with tissue viability nurse to treat wounds and with physiotherapists in biomechanics clinics. Pharmacy staff were part of the independent rehabilitation teams and the symphony project. Psychologists were available to the cardiac rehabilitation service. Therapists working in splinting clinics were working closely with the independent rehabilitation teams to ensure an integrated approach to the patients seen.

- Arrangements for working with social workers had recently become disjointed from the community health services for adults. The independent rehabilitation teams had previously included social care staff .Two weeks prior to our inspection, this integration had been suspended and social care staff were now managed by the local authority. Rehabilitation staff expressed some concern regarding the future multidisciplinary working arrangements with social care colleagues. In one team the manager had ensured that 'hot desks' were available to encourage social care staff to work alongside the rehabilitation team where possible. Rehabilitation staff were positive that the removal of social care responsibilities from their roles would enable them to focus their rehabilitation skills more effectively.

Referral, transfer, discharge and transition

- The arrangements for managing the transition of patients between the acute trust and the community health services for adults was not always clear.
- Therapy and district nurse teams told us that they felt the effect of poorly prepared discharges from acute inpatient settings. Some patients were discharged from inpatient services before the therapy was complete or at an optimum level for discharge. This affected staff that were then required to respond urgently to unmet needs.
- There was no evidence of a consistent approach to communication with the acute trusts regarding inpatients that may have been known to the community teams.
- The independent rehabilitation teams had recently refined their referral criteria and this had been successful in reducing the number of inappropriate referrals received. There was a lack of clarity regarding the service specification for rehabilitation services and the referral system for weekend working was not clear.
- The ongoing plans following discharge from the district nursing service or the independent rehabilitation teams were not recorded. The teams did not write a written discharge summary for GP's but did communicate with the GPs using electronic messaging, phone call or face to face communication. The district nursing service did not have a handover policy. The handovers between shifts that we observed were brief.
- The pathway for assessment or review of continuing healthcare needs or funded nursing care needs for patients in a nursing home was unclear and inconsistent between localities, for both routine and urgent assessments.

Access to information

- Not all the information needed to deliver effective care and treatment was available to staff in a timely and accessible way.
- There was a reliance on the duplication of information in paper and electronic form due to access and connectivity issues with the electronic record keeping system. This had an impact on teams across the service. The 'store and forward' mechanism, which was designed to enable staff to upload patient details prior to their visit, did not work consistently or reliably. When nursing staff received a referral for a new patient and they were geographically far from their base, visits were made to new patients without up to date medical and social information which may contain important alerts to protect the safety of staff and patients. However no data was available to quantify this risk because staff did not complete incident forms when this occurred.
- Dietitians holding clinics in GP surgeries where connectivity to the electronic record keeping system was problematic. Dietitians were e required to document patient care in a different format which was saved to memory stick and then copied into the system at a later time. The GP record keeping system was unable to communicate with the trust electronic record keeping system so records were then inputted on to the GP system resulting in duplication of the workload. These factors had a significant impact upon the use of the electronic record keeping system and the feasibility of 'mobile working'.
- The impact of the problems with connectivity for the community health services for adults was not included

on the divisional risk registers. There were intentions to investigate provision of a roaming device to resolve this connectivity problem. However, no staff or managers were able to tell us how this was progressing.

- Nurses told us they experienced difficulty tracing the records of patients in nursing homes who required reviews of their continuing healthcare or funded nursing care needs. Information provided from the continuing healthcare team of the clinical support unit was minimal. Nurses were sent a copy of the letter written to the patient or their spouse that lacked basic details such as the name and address of the nursing home. This impacted upon workload as time was spent tracing essential information.
- In clinic settings such as podiatry where wireless internet access was available, the electronic record keeping system was being used effectively to share information with other teams and to update and view progress. Some services such as cardiac rehabilitation used the electronic record keeping system to share information effectively, but they still relied on paper format in some situations e.g. medication records. In independent rehabilitation teams, therapists reported feeling confident in the use of the electronic record keeping system.
- In the orthopaedic service therapists dictated letters were transferred via a secure server to administrative staff who were able to type these letters without delay.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Although uptake of formal training regarding the mental capacity act was low, consent was routinely discussed with patients. Nursing and therapy staff understood their responsibilities with regards to obtaining consent. Records included a confidentiality agreement which detailed how data would be shared. Therapists discussed this document with patients and gained verbal consent prior to treatment. Nurses were observed to obtain verbal consent from patients and this was recorded in the progress notes we reviewed. Patients confirmed that their consent was sought before treatment.
- According to data provided by the trust, on average only 65.9% of staff in the community health services for adults had completed training in the mental capacity act. Some teams, such as continence, diabetes, cardiac rehabilitation, stroke, plus district nursing teams at Taunton and North Sedgemoor and the independent rehabilitation team at Taunton were all lower than this average. All staff in Community matrons and telehealth teams had completed this training.
- A nursing team manager confirmed that although frontline nursing staff had good understanding of the need to obtain consent, they were unlikely to complete a mental capacity assessment. The need for clarity regarding the mental capacity of patients was identified in two serious investigation reports (4 February 2015; 31 January 2015) regarding the development of community acquired grade three pressure ulcers. In both of these investigations, a patient had developed a pressure sore but had declined interventions and their mental capacity had not been recorded. This meant that the need for the initiation of a best interest decision making process may not have been formally considered.

Good

Are services caring?

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

Summary

The community health services for adults were caring District nurses and therapists were respectful, professional and kind. There was good rapport with patients who were treated with dignity. Patients said that staff understood their needs and patients felt involved in their care. Staff used creative techniques to educate and encourage understanding of patients and relatives. Physiotherapists in the musculoskeletal service had received training in shared decision making skills.

Patients were given emotional support to help them to cope emotionally with their condition. Referrals could be made to the 'talking therapies' service for emotional health checks. The 'Life after stroke' group at Williton provided emotional support for patients following stroke

Detailed findings

Compassionate care

- Staff in the district nursing and independent rehabilitation teams took time to interact with patients. There was laughter between the patients and staff and it was evident that good relationships were in place between them meaning that difficult procedures were undertaken with consideration and respect for each other. We observed personal care being provided and saw patients were treated with dignity and respect. Patients were offered help to go through to their bedroom for treatment in order to maintain privacy.
- Patients who had recently been discharged from the district nursing and the independent rehabilitation services said they had been treated as an individual. Therapists were observed to show respect in patient's homes when visiting. Therapists were professional and kind in their approach to care.
- A county-wide recruitment drive had taken place using 'interviewing for compassion' techniques to ensure the right type of candidates were shortlisted for interview.

Understanding and involvement of patients and those close to them

- From April 2015 to June 2015, the trust received 2420 responses from the friends and families test. Low numbers of responses were received from the community health services for adults; 51 of these responses were from district nursing and 124 responses were from the independent rehabilitation teams. On average 91.6% of respondents would recommend the district nursing service and 93.1% of respondents would recommend the service from the independent rehabilitation teams.
- The trust completed an audit of the NICE quality standard 'Patient experience of adult NHS services' in January 2014. This identified that staff introduced themselves to patients and patients felt their care was tailored to their needs and circumstances. We spoke with 19 patients who had recently been discharged from services and they consistently told us that they had felt involved in their care and that staff understood their needs.
- In the cardiac rehabilitation service, carers were encouraged to attend clinics, this reduced anxiety amongst patients and their carers. In the orthopaedic assessment service, therapists were observed to give clear explanations of treatment options, using models of the spine to aid understanding and to facilitate informed patient choice. In the diabetic retinopathy clinic, staff gave clear explanations of the anatomy and physiology of the eye to aid patient understanding of screening options.
- In the musculoskeletal service, patient questionnaires had identified that patients wanted to feel more involved in their treatment. As a result physiotherapists attended training in shared decision making and consultation techniques. We checked three sets of notes and saw evidence of this approach.

Emotional support

- We saw that therapists in the independent rehabilitation teams were supportive. We saw instances when they tailored their knowledge of the patient to provide emotionally support, identifying positive outcomes and recognising success. Occupational therapists discussed patient's emotional wellbeing and offered support.
- The long term conditions team provided a 'Talking Therapies' service which offered emotional health checks. The health check was a 15-20 minute telephone discussion that considered the emotional health of

Good

Are services caring?

patients alongside their physical health, their changes of life circumstances or as part of their care whilst awaiting treatment. Referrals were made by the patient or other health professionals.

- In the 'life after stroke' support group, there was a relaxed atmosphere that encouraged patients to ask the visiting speakers questions and gain emotional support.
- According to the 2011 census, 58,300 people in Somerset were carers. The trust did not have designated carer champions, however nursing and therapy staff did consider the needs of carers when assessing patients.

Requires improvement

Are services responsive to people's needs?

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

Summary

The district nursing and independent rehabilitation teams were not planned and delivered in a way that systematically took into account the specific needs of the local population, nor did they actively seek involvement of patients in the design of service delivery. Patients whose needs were not urgent were not able to access an initial assessment in a timely way. During April 2014 and March 2015, 865 patients had waited more than six weeks for an assessment in the independent rehabilitation teams. In the same period, 115 of these patients had waited more than 18 weeks. For podiatry, 88 patients had waited more than 18 weeks for an assessment. Patients receiving continuing healthcare and funded nursing care waited a long time for nurses to review their needs.

District nursing and independent rehabilitation teams were able to respond quickly to patients whose needs were urgent. The district nursing teams had been reconfigured in order to respond more flexibly and equitably to variations in demand across locations. Nurses and therapists were able to respond to patients by visiting them in their own homes within 24-48 hours. The independent rehabilitation teams offered seven days per week service but this was not consistently available. A band seven clinician triaged all referrals via a single point of contact in each location. However, referrals to speech and language therapy sometimes waited two weeks to be triaged. This meant that patients at high risk might not be directed to appropriate treatment in a timely way.

There were good examples of learning from complaints. There were several projects that had developed to meet particular needs such as the district nursing ambulatory care clinic and services were flexible to accommodate changes in demand. Access to the interpreter service was good and had been used effectively in the district nursing teams

Planning and delivering services which meet people's needs

- Within the district nursing service and the independent rehabilitation teams, there were no systems in place to ensure that service delivery was planned to meet the specific needs of the local population. There was very limited involvement of patient groups in the planning of service delivery within the district nursing service or the independent rehabilitation teams. These teams did not seek to identify unmet needs.
- The district nursing service was based upon a federation model of service delivery, offering flexibility within the district nursing teams to respond to variations in service demand across locations. Staff tried where possible to accommodate patients' needs, such as scheduling visits to arthritic patients later in the day. The ambulatory care clinic operated from Monday to Friday between 9am and 5pm, and on Saturdays and Sundays between 9am and 1pm. Opening times were flexible to meet patients' needs. Nurses gave an example of re-opening the clinic to accommodate the needs of patients having chemotherapy over the weekend.
- Over winter last year, the overnight nursing service developed a night sitting service. This was a team of health care assistants who worked alongside three teams to provide an overnight sitting service for high-risk patients. This service aimed to reduce unnecessary hospital admissions during a period of high demand for inpatient services. This was particularly beneficial for patients receiving palliative care who were able to stay at home for their end of life care.
- Clinics and services were run in a location that were close to patients home or in their local community. The cardiac rehabilitation team scheduled classes in a variety of venues such as rugby clubs and leisure centres across the county. For these patients unable to attend clinic, they were given a home based programme and offered telephone support. The splinting service fabricated thermoplastic splints for patients in their own homes, ensuring a more holistic understanding of the needs of patients and reducing travelling distances for patients. The Parkinson's disease nurse ran clinics at different times of the day at different venues to encourage accessibility. This nurse also visited patients in their own homes. A joint physiotherapy and Parkinson's disease clinic was held on alternate months in Wells, enabling patients with needs for both specialists to be seen at the same clinic.

Requires improvement

Are services responsive to people's needs?

- However, there were some areas where clinics and services could not be delivered There was no dietetic input into mental health and there was no specialist dietetic service for patients with coeliac disease In Yeovil patients who had experienced a fall were not able to access a strength and balance class because there were no suitable locations to hold the class. These risks were not referenced on any of the divisional risk registers and an action plan was not evident.
- In the early supported discharge service for stroke patients, a report was completed each time a patient was admitted to a stroke rehabilitation unit, which considered the reasons why a patient was not suitable for early supported discharge in order to understand the needs of patients that could not be supported by the service.

Equality and diversity

- In order to take account of the needs of people with restricted mobility, the district nursing service and the independent rehabilitation teams visited patients in their own homes. This meant that people with disabilities were able to access nursing and therapy services on an equal basis to others without disabilities.
- Equality and diversity training was available to staff as a means to address inequalities within the care provided in the community health services for adults. In the trust wide staff friends and family survey, only 50% of staff were identified as having equality and diversity training in the last 12 months. This was 17% lower than the national average.
- In the community health services for adults, staff demonstrated understanding of equality and diversity concepts. One nurse explained how she had a patient who was a Jehovah's witness and their cultural preferences had been recorded in their care plan.
- There were arrangements in place to enable convenient access to translation services. Staff consistently reported good access to interpreter service for non-English speaking patients. One Latvian-speaking patient who was nearing the end of his life was discharged from an acute setting to a nursing home. The care staff at the home alerted the district nursing team to their suspicions that the patient did not understand his prognosis. Nurses accessed the interpreter service and were able to talk through all his concerns as well as establish his wishes about where he wanted to die and be buried. Through the interpreter, they were also able to contact the patient's family to discuss his care plan.

Meeting the needs of people in vulnerable circumstances

- In 2015 it was estimated that there were 2,036 people aged 18 years and over with a moderate to severe learning disability living in Somerset. The community health services for adults were not proactively planning services in order to meet the specific needs of people with a learning disability but staff were able to refer to the learning disability service within the trust if they felt unable to meet the needs of patients with a complex learning disability.
- In 2015, 9100 people in Somerset were estimated to have dementia. The trust had 35 staff who were dementia champions; two of these were available in the community health services for adults. These members of staff shared learning within their teams and made suggestions such as using a different coloured folder to identify patients with dementia.
- The planned implementation of the 'integration phase two' project was intended to reorganise the way that services were delivered in order to facilitate a more coordinated approach to meeting the needs of patients with complex needs.
- No actions had been taken within the community health services for adults to specifically remove barriers for people who may find it hard to access services such as homeless people or traveller communities.

Access to the right care at the right time

- Patients whose needs were not urgent did not consistently receive a timely response from either nursing or therapy staff.
- Patients who required a review of their continuing healthcare or funded nursing care needs waited a long time for this to occur. Within the west of Somerset, the average waiting time for a continuing healthcare review was eight months. Within the east of Somerset, the average waiting time for a continuing healthcare review was six months. This meant that healthcare

professionals did not have an up to date understanding of the clinical needs of frail patients living in nursing homes and, as such, those patients might not have been receiving adequate or appropriate care.

- District nursing staff told us that this workload was increasing. However, retrospective data was not available for comparison. The increase in demand to complete the continuing healthcare assessment and reviews of patients in nursing homes was identified on the Taunton and Mendip risk registers. Part of the mitigation of this risk was the establishment of four small teams had been established across the county to focus upon completion of the continuing healthcare and funded nursing care reviews of these patients. The capacity of these teams was outweighed by demand. In one location, 215 patients were due for a review of their needs at the time of our inspection, with 169 of these overdue. Data held by the continuing health care team within the clinical commissioning group identified that 215 assessments were outstanding from 1 June 2015 to 14 September 2015. The assessment teams were unable to provide an equitable service across the patch resulting in district nursing teams attempting to cover the shortfall in rural areas such as Williton and Minehead.
- The data provided by the trust for waiting lists in the independent rehabilitation teams applied to the period from April 2014 to March 2015. This data was not discipline specific and did not take account of the recent separation of social care responsibilities from the independent rehabilitation teams as this did not occur until 1September 2015. Team leaders and senior management told us that the target response for waiting times for occupational therapy and physiotherapy within the independent rehabilitation teams was six weeks. During this period, 865 patients had waited more than six weeks for an assessment. One hundred and fifteen patients had waited more than 18 weeks, 88 of these in Yeovil locality. In Williton, the longest waiting time for independent rehabilitation team physiotherapy was eight weeks and there were 50 patients waiting. Physiotherapy and occupational therapy were vital components of the rehabilitation pathway and delays to assessment and treatment may have resulted in further deterioration of patients at risk of losing their independence.
- Patients did not have timely access to a routine podiatry assessment. Data from the trust identified that 88 patients had been waiting more than 18 weeks for a podiatry assessment, the longest wait being 48 weeks. Forty-five of these patients had been waiting under 20 weeks. The podiatry service was offering a clinic service six days per week, including priority clinics where patients with urgent needs were seen within 24 hours.
- The adult dysphagia pathway used by speech and language therapists sanctioned the use of telephone review instead of face-to-face assessment for low risk patients. Patients with dysphagia present with difficulty swallowing, which, depending upon severity, can result in a risk of choking or chest infection. Effective and timely triage by a speech and language therapist is essential to identify high-risk patients. The adult dysphagia pathway did not identify a target time for triage. The speech and language team were short of staff due to long-term sick leave. This lack of availability meant that some referrals were waiting two weeks until they were triaged.
- There were six patients waiting more than the 18-week target response time for the orthopaedic assessment service. All referrals in the orthopaedic assessment service were received by email and screened electronically by clinicians to ensure timely triage. The orthopaedic assessment service aimed to see and complete all treatment and diagnostics within six weeks, with signposting and referral on to relevant services on discharge. This ensured that the patient pathway was not delayed if specialist intervention was required.
- The talking therapies service had seen 93.4% of new referrals, i.e. 4306 patients within six weeks of original referral, and 99.5 % of new referrals within the national target of 18 weeks. Seventeen patients had waited longer than 18 weeks, with 36 weeks being the longest wait. The impact of delay in treatment of psychological distress could hinder the patient's ability to self-manage their long-term conditions.
- The musculoskeletal service had received 12% more referrals in 2015. The musculoskeletal service at Yeovil saw all patients within six weeks of referral, and urgent referrals were assessed within two weeks. Patient self-referrals were stopped because the service was unable to meet the demands. The new referral system required patients to attend their GP who prioritised the referral and gave the patient the contact details of the service for them to make an appointment when they were

ready. This option meant that patients could respond individually based on need. There was also a 'physio-direct' telephone information service for urgent advice. This system had reduced the rates of non-attendance to the clinic to 2% for new patients.

- Patients with urgent needs had timely access to initial assessment and treatment. District nurse teams were available 24 hours per day, seven days per week. In every community nursing hub, one member of staff was available to coordinate referrals between 8am and 6pm. There was a dedicated line for clinicians. There was no agreed triage pathway to determine when a patient should be visited, and waiting times for urgent patients were not routinely monitored. However, coordinators tried to ensure that urgent visits were prioritised and patients with urgent needs were seen within 24 to 48 hours.
- Access to the appointment system was dependent upon the availability of the hub coordinator. On 7 September 2015, the district nursing hubs received a total of 565 calls with 18 calls unanswered. Incident reports showed that on two occasions, lack of available frontline nursing staff resulted in the band 6 coordinator attending nursing visits leaving the administrative staff to cover the coordinator role at the hub. These staff were not clinically trained. The administration personnel received complaints regarding the length of time to answer the hub telephone.
- District nurses also facilitated clinics for patients who were able to travel to a clinic setting. This included a leg ulcer clinic at Chard Community Hospital, all other leg ulcer clinics were provided by a designated specialist service. The ambulatory assessment unit enabled patients from the community to receive treatment without a hospital admission. This included intravenous antibiotics and wound care. Patients told us they liked the facility as it provided a prompt service. The district nurse teams told us that it helped to reduce some of their workload as patients they may have seen in the community could be treated at this unit.
- Patients with urgent needs for rehabilitation had timely access to initial assessment and treatment. The independent rehabilitation teams operated a duty coordinator system on weekdays. The coordinator triaged referrals and urgent referrals were allocated urgent appointments within 24 to 48 hours. These response times were not monitored. This system had reduced referrals by half as they were filtered appropriately and they were able to send the right team member to the patient first time. The coordinator was able to be flexible when offering appointment times as therapists diaries were available for the coordinator to view on the electronic record keeping system. This flexibility was observed when therapists booked follow up appointments with patients.
- The urgent needs of patients requiring rehabilitation at weekends were not consistently met across all geographical areas. The independent rehabilitation service aimed to provide therapy cover from 8.30am to 4.30pm on seven days each week. The service was not commissioned to cover weekends and existing staff were expected to cover weekend shifts as part of their normal rota. Staff vacancies may have impacted upon the weekend cover however, data from duty rosters provided by the trust did not accurately reflect the actual staffing levels achieved. Weekend working arrangements were in place across the service area and each weekend a Team Manager or Specialist Therapist was in place to co-ordinate urgent discharges or community priorities, and to coordinate staff to meet demand.
- The early supported discharge team for stroke patients aimed to facilitate shorter inpatient admissions and promote improved recovery. This service was responding to referrals within 24 hours for patients discharged from hospital and within 72 hours for patients referred from the community.
- In some services, rates of non-attendance for appointments were high, for example, 10% for the Parkinson's disease specialist nurse and13.3% for community dietetics. This affected upon the efficient use of staff time.

Learning from complaints and concerns

- There had been 21 complaints in the community health services for adults during the 12 month period preceding our inspection. Of these 15 were upheld. Complaints were managed and monitored via the governance team and investigated locally within teams who developed local actions plans. Learning from complaints was shared via local team meetings, team leader meetings and at the countywide best practice groups. Learning was shared corporately via the clinical governance meetings or operational management

meetings. A member of staff in the independent rehabilitation team was observed to explain the complaints procedure when required and to apologise when a mistake was made.

- We heard an example of a patient's daughter attending a best practice group to educate staff around the issues the family had experienced when their mother received care from the district nursing team at the end of her life. We heard another example of a complaint regarding a palliative care patient whose needs were not addressed by the twilight team because the geographical extent of their patch was so large. As a result, the twilight team covered a smaller area.
- In musculoskeletal physiotherapy, a patient reported that they were unhappy with the timeframe of a referral from the minor injuries unit to musculoskeletal physiotherapy. As a result, a review of the referral system took place and a more direct access referral system was implemented.
- A peer review inspection carried out by the trust of the Shepton Mallet outpatients department, identified that staff felt able to raise concerns regarding patient care and felt their voice was being heard.
- A district nursing GP survey had proactively sought feedback from GP's in response to a new model of working for district nurses. Actions were timetabled to address concerns regarding communication that were raised in this survey.

Requires improvement

Are services well-led?

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

Summary

Measures to protect the safety of staff who worked alone and as part of dispersed teams were not adequate. The system for ensuring the safety of staff working on overnight nursing shifts in the community was not fit for purpose. The trust did not have arrangements in place for reviewing the health and safety of night workers.

Public engagement was evident in the specialist services but was minimal within the larger services such as district nursing or the independent rehabilitation teams. Staff engagement had focussed on the implementation of a new model of integration for community services. Although staff were positive about the benefits of further integration, managers were unable to explain how progress against the delivery of the strategy would be monitored or how benefits would be measured.

Divisional risk registers reflected the risks evident in the teams we visited. The more severe risks were escalated to the board risk register. There was a lack of ownership of the risk associated with unreliable wireless internet connectivity and this was not deemed as a risk at board level. There were action plans in place to address the risk resulting from increased demand and decreased capacity in the district nursing service but action plans regarding key risks in the district nursing service were not reliably cascaded through all levels of the organisation. At sub-divisional level, there was a breakdown in the flow of information and this resulted in deputy divisional leads being unaware of information about key aspects of the services they managed. Leaders on the front line were not aware of progress with mitigation plans for key risks affecting the service.

Service vision and strategy

- Staff were aware of the trusts vision for the community health services for adults. The trust had begun a process of transformation of services called 'Integration phase two'. This incorporated new ways of working for community teams focussed on integrated approaches to care. In the community health services for adults, the focus of the integration was centred on District Nursing, Older People's Mental Health Services and Integrated Rehabilitation Teams.
- the focus of this integration was centred on the integrated older peoples and long-term conditions teams.
- A new management structure came into being in August 2015 to reflect the new integrated model of service. During our inspection, many of the appointees to posts created in this restructure had not commenced their role and further progress appeared to have halted whilst awaiting new managers to be in position.
- Staff were aware the implementation of 'integration phase two' was going to occur and were positive about the perceived benefits of further integration. Staff felt they had been consulted and some were participating in working groups, but there was no awareness of an action plan specific to this development at frontline or middle management or senior management level. Staff did not know what their role would be in achieving the vision of integrated care. Managers were unable to explain how progress against the delivery of the strategy would be monitored or reviewed or how the success of the change would be measured.
- Managers cited the 'releasing time to care' agenda as pivotal in freeing up time for nursing staff to see patients. This was a plan to become less bureaucratic with more emphasis on use of technology to aid documentation and reduce travel time. This innovation was dependent upon the successful operation of mobile working for community teams. However, connectivity to mobile phone networks and wireless internet were evidently problematic during our inspection.

Governance, risk management and quality measurement

- Lines of accountability were unclear at deputy divisional management level. Three deputies' divisional leads advised us that channels of information were not straightforward. Risks were escalated via band 7 team

managers to the deputy divisional leads and divisional leads and on to the board. Feedback from board discussions was channelled down to the best practice groups and any action plans were disseminated to the clinical staff, missing out the deputy divisional leads. As a result, the sub-divisional management level was not always clear about the actions taken.

- Overall, there was alignment between the recorded risks on the risk registers and those risks faced by staff on the frontline and there were credible action plans to mitigate risks. However, there was a lack of ownership of the risk associated with unreliable wireless internet connectivity and this was not deemed as a risk at board level. Although we were told that this issue was being addressed by the electronic record keeping system operational group, frontline staff and management staff were unaware of any progress with this issue.
- Leaders at service level were aware of the risks affecting the quality and safety of services they delivered. There were four divisional risk registers, one for each locality. Any risks scoring 12 or above were reported to the divisional manager. In some locations, staff were not aware that these registers existed and did not know what risks were identified on them. Leaders were not aware of progress at board level with mitigation plans for key risks affecting their service.
- At the time of our inspection, there were insufficient processes to assure the safety of staffing levels in the district nursing services. The arrangements for identifying critical risk regarding staffing in the district nursing service on a day to day basis were not proactive. Managers did not have an accurate and up to date measurement of the demand and capacity within the district nursing service.

- Issues such as staffing were discussed at a monthly operational catch up meeting, attended by the heads of division, deputy heads of division and service leads. We were advised that some measures had been put in place to ease workload pressures for district nurses including the introduction of ambulatory care units and a phlebotomy service. A capacity review of the district nursing service had been drafted for presentation to the clinical commissioning group. This document outlined the pressures within the district nursing service and outlined the investment required to provide a safely staffed service. A recruitment plan was in place. The district nursing quality improvement plan dated August 2015 targeted several risks identified in our inspection, including: capacity issues; increased number of timed visits; care management within nursing homes; low reporting of incidents; problems associated with the electronic record keeping system; and the duplication of paper and electronic records. This plan included specific action points for all these risks with identified personnel to carry these forward by specific dates. .

- The risk registers at local level identified key risks evident during our inspection. The demand in the district nursing service was rated as high risk on all the local risk registers except for Taunton locality. This risk was documented as having potential implications on staff in terms of stress levels, health problems, not maintaining training and work life balance, lack of support, isolation, poor communication, and potential for clinical errors. For patients, the lack of capacity in the district nursing service was identified as causing potential delay and errors in treatments; and for the trust, the potential implications were listed as delay in nursing assessments; increase in complaints; increased resignations; increased sickness due to poor morale and loss of good will from staff. This risk was also identified on the corporate risk register. The action planned to mitigate this risk was the implementation of the integration phase two project that would incorporate caseload zoning and improved efficiency.

- The unmet needs of patients living in nursing homes who required a continuing healthcare review was identified on all of the local risk registers except for Bridgwater and North Sedgmoor. Plans to reduce the risk highlighted the need for more social worker availability. Other risks identified on the divisional risk registers included poor remote access to information technology systems, no access to the electronic record keeping system used in GP practices; no access to wireless internet from non NHS sites; no access to clinical records from other services; increased caseload of insulin administration timed visits; insufficient capacity in the diabetic eye screening to meet screening targets; reporting of the malnutrition universal screening tool scores, podiatry waiting times specifically inability to cover priority ulcer clinics and the diabetes service, and mandatory training. Actions to mitigate these risks were evident.

Requires improvement

Are services well-led?

- The board risk register also identified pressures in the musculoskeletal services relating to increasing numbers of referrals to the orthopaedic assessment service. Actions to mitigate this included the monitoring of referrals and waiting times and reviewing of the contract with the clinical commissioning group.

Leadership of this service

- Deputy divisional leaders admitted that due to recent changes in management structure, they did not understand the challenges to good quality care in the community nursing and therapy services. They were unable to identify the progress made with actions to address these challenges.
- In the trust wide staff survey, the percentage of staff reporting good communication between senior management and staff was below the national average. In the community health services for adults, this was an average of 28.5%. Many staff we spoke with felt disconnected from the executive board. More positively, the same survey identified that an average of 87.2% believed the trust provided equal opportunities for career progression and 87% had received job relevant training, learning, or development in the past 12 months.
- At a local level, staff were unanimous in their praise for their team leaders and managers. Team managers and band 7 team leads were approachable. Staff and local managers felt supported in their roles, despite the workload strain they were experiencing. Talking therapy staff and the cardiac rehabilitation service told us that they felt well led at a local level and had updates by email from the board.
- The voice of therapy at board level was limited as this was channelled through the director of nursing, and it was acknowledged that therapy priorities competed with the more prominent voice of district nursing. A newly appointed 'head of therapies' would be responsible for raising the profile of issues relating to therapy at senior management level.
- The children's directorate managed the cardiac rehabilitation service; staff felt this added extra challenge to facilitation of multidisciplinary working with other teams providing services to adults in the community.

Culture within this service

- Measures to protect the safety of staff who worked alone and as part of dispersed teams were not adequate. The system for ensuring the safety of staff working on overnight nursing shifts in the community was not fit for purpose. The trust lone working policy relied upon the availability of a mobile phone signal or wireless internet connectivity and a rapidly accessible schedule of appointments that included times of arrival and departure at each appointment. Both of these measures were not reliably available for district nurses working overnight shifts.
- The system for tracing staff was not reliable. Nurses were checked in at the beginning of their shift 9.45pm, and then again at the end of their shift at 8am. During their shift, the overnight nursing service received new referrals via the non-emergency medical helpline. If a nurse was telephoned by this service but they did not answer their phone, the non-emergency medical helpline service telephoned the nurse on the other side of the county to allocate the referral. There was confusion amongst managers and staff regarding the process that the non-emergency medical helpline would then initiate if staff were not answering their phone. Frontline staff told us that it was accepted practice that staff may not answer their phone if they are busy with another patient or if they are out of signal.
- The trust informed us that there was a buddy system in operation overnight. The three teams were expected to telephone each other to ensure that they know where they all were throughout the night time period, and then escalate concerns to the on call manager. In rural areas such as Wiveliscombe, staff had no mobile signal so were routinely unable to respond to new referrals or summon help if required. The nurses electronic diaries itemised which patients were booked to be seen during an evening, but these were not necessarily visited in sequence as nurses prioritised according to greatest clinical need.
- For the nurses working the twilight shift, the risk was lessened by the availability of the hub coordinator, but the system for ensuring their safety was not robust. Nurses covering this shift were required to inform the coordinator when they were going off shift, and to inform the overnight nurse if their shift ran over time. The trust lone working policy stipulated that regular traceability audits should be completed. No data

regarding traceability audits was forthcoming from the trust. An incident report described the difficulties encountered when an on-call manager was called to investigate because two nurses working on the twilight shift had failed to 'clock-off' with the coordinator at the end of their shift. The on-call manager had no access to the personal contact details of these nurses. The nurses had informed the nurse on the overnight shift but this was the last person that the on-call manager contacted.

- In one location, nursing staff told us that they feared for their safety when working after dark. One incident report described a situation where a nurse was required to stay with a patient who had fallen whilst awaiting paramedics. She had no phone signal so used the patient's landline to inform the coordinator that she was without a mobile phone signal and explain that she would be delayed by one hour. The ambulance took two and a half hours to arrive and in that time no one called to check on her safety.
- The trust informed us that in the night time period the three teams shared resources. If there was no healthcare assistant on duty in one team, the resource was shared across the three teams and visits were undertaken following a risk assessment. Only nurses at band 6 level worked in the overnight period due to the unpredictability and complexity of the urgent care calls that required triaging for priority of care and geographical location across the county as a whole. When there was no registered nurse on duty in one of the three teams, the other two registered nurses covered that area. However, nursing staff told us that the geographical distance between locations meant that sharing resources was impractical and they were unsupported during times of staff shortage. Nursing staff told us that it was accepted practice that nurses attended visits alone when on the twilight shift. They had escalated their concerns to their manager but had not used the electronic incident reporting system to record specific incidents.
- Managers reported that on several occasions the information received from the non-emergency medical helpline had been insufficient. This placed patients at risk because staff could not adequately prepare to meet their needs and placed staff at risk because an adequate risk assessment of staff safety could not be undertaken prior to the visit. These incidents were not reported on the electronic incident reporting system so actual data of frequency was not available. The manager accepted that the team relied on the experience and local knowledge of staff to determine if a patient represented a risk.
- District nursing staff were not able to see mental health alerts on their electronic record keeping system screens. The electronic record keeping service could only be checked back at base, and nurses did not return to base between visits due to the distance between locations. One incident report described how a nurse had been working alone during a twilight shift and had been called to attend a patient not known to them. Once back at base, she was able to check the patient's electronic record and discovered that both the patient and their family were known to be aggressive towards staff.
- District nurses had access to 'twilight boxes' that contained a satellite navigation system, a reflective vest, a folder with contact numbers for on-call managers and phone number or equipment. Staff had no personal alarms.
- There was no system in place to monitor the lone working of the Parkinson's disease specialist nurses. In the independent rehabilitation teams, lone working protocols varied across locations. In one team, therapists took turns to check each day if staff had returned to base by 4.30pm. At weekends, the risk in the therapy teams increased because urgent referrals were actioned but not recorded on the electronic record keeping system so the whereabouts of staff was not documented. There were not always sufficient staff on duty to attend visits in pairs. In some teams, this risk was mitigated because therapists were able to telephone the band 7 therapist 'on call' for the weekend when going on a visit. In one team, a manager explained how she had responded to an incident where the safety of two staff had been at risk from an abusive patient. She had taken all relevant measures to prevent future incidents involving this patient and shared learning within one hour of the event.
- The Workplace Health and Safety Standards Assessment Action Plan dated April 2015 identified that the Trust did not have arrangements in place for reviewing the health and safety of night workers.
- The trust was using an internally developed 'Pulse' Survey to measure culture within teams. The survey is sent out as a response to certain triggers such as low

staff friends and family test, high sickness rates, high staff turnover, low key performance indicators, and high performing teams. However, data gathered so far in the community health services for adults was not conclusive, as it had only been used in one department in one hospital that included only four members of staff.

- In the staff survey of 2014, an average of 22% of staff working in adult community health services reported experiencing harassment, bullying, or abuse from staff in the last 12 months. One member of staff had used the trust whistleblowing system and had felt well supported throughout the process. The staff we spoke with felt valued by their local teams and they were proud of the service they delivered.

Public engagement

- The views and experiences of the public were not systematically gathered and acted upon to shape and improve the district nursing service or the independent rehabilitation teams. In the district nursing service there were no public engagement activities, other than the friends and families test.
- There were isolated examples of public engagement that focussed upon particular areas. The diabetes service had two patient representatives on the diabetic retinopathy eye screening programme board. A diabetes open evening had been held at a local surgery in March 2015 to raise awareness of diabetes to over 100 members of the public.
- Within the independent rehabilitation teams, patients participated in an equipment review group. Issues highlighted at this group resulted in a change of practice. For example, rehabilitation staff now asked service users if they wanted anyone else to be present when assessments were booked.
- A survey of patient and carers communication needs following stroke was completed in September 2014. This survey had guided service planning concerning the aphasia support at Williton Hospital. An evaluation of speech and language therapy in October 2014 had used patient feedback to inform future management of appointments.
- The cardiac rehabilitation service had conducted a survey to gain patient feedback and had used this to improve communication at point of receipt of referral. In the diabetes service, an audit of patient experience had identified that early morning reminder texts from the service were unwelcome and so these were rescheduled to occur later in the day.
- The orthopaedic assessment service had arranged bespoke patient focus groups and these had led to introduction of telephone follow up appointments to reduce rates of nonattendance.
- The symphony project engaged the views of their patients via a patient experience group that offered comments and suggestions for improvement. The Talking Therapies team had identified patients who were then included as part of staff interview panels in the long-term conditions team.

Staff engagement

- Prior to March 2015 the programme of visits from the executive team had not included community teams. In July 2015, a series of consultation events were held at venues throughout the county to discuss integration phase two with community staff. In August 2015, the project implementation group reviewed the proposed models of service delivery in light of the consultation. Staff we spoke with were not aware of feedback from these events.
- The trust had a standing staff forum called Voice box, which met regularly to discuss issues raised by staff.Feedback from these discussions was raised at the workforce governance group, but no action plans were agreed. The trust was developing a wider staff engagement programme linked to the staff survey that was scheduled to commence in August 2015 but had been rescheduled.

Innovation, improvement and sustainability

- In the district nursing and independent rehabilitation teams, team managers and staff were focussed on delivering good quality care. However, as there was limited feedback available from outcome measures or from public engagement, information was not used proactively to improve care.
- One band 7 nurse told us that they felt they had many responsibilities but no real authority to make improvements. We were told of several improvement projects that had been suspended by more senior management without clear rationale explained.

Requires improvement

Are services well-led?

- In the trust wide staff survey only 68% of staff felt able to contribute towards improvements at work, this was 8% lower than the national average. Following a call for ideas for improvement, the trust received 60 proposals from teams for innovation, and in March 2015, these were awaiting permission for approval. Staff in the community health services for adults were not aware of any of these projects but had shared innovative ideas with local management. The process for escalating ideas to the board was not clear.
- There were plans in place within the talking therapies service for an emotional health check to be made available on line. This would widen the availability of the service. There were also plans for webinar courses to be made available to provide courses to patients at home.
- There were some good examples of partnership working with acute trusts and with the clinical commissioning group. For example, 'Symphony' was a twelve-month project in Taunton in collaboration with the local acute trust, the clinical commissioning group, and local G.P. surgeries. The project identified patients on GP registers who had capacity to proactively self-manage their long-term condition with additional signposting or support and involvement of family or carers. Patients on this programme were encouraged to direct their own consultations with band three wellbeing advisors. These advisors were managed by the clinical commissioning group and received clinical leadership from the community matrons. Another model of proactive self-management of long term conditions called 'Better Living' was being piloted in Minehead in collaboration with the local G.P.'s, Age UK and the clinical commissioning group. Volunteers worked with patients to help them to resolve obstacles to reaching their goals. Nursing staff were referring patients to partners in voluntary agencies and community groups to access support.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9 (3)a;** **Carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.** **District nursing staff were not consistently completing essential risk assessments and basic observations to enable early detection of risk to patients health.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18 (1);** **Staffing: Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.** **People who use services were not protected against potential harm because there were insufficient members of staff to provide a safe district nursing service.**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17 (2)b;** **Good governance: Assess monitor and mitigate risks relating to the health safety and wellbeing of service users and others who may be at risk which arise from the carrying on of the regulated activity.** **Protocol and practice in the community health services for adults did not adequately protect staff who were working alone in patients homes.** **The district nursing service did not use an appropriate staffing tool to calculate staffing requirements. This meant that safe staffing levels could not be reliably confirmed or audited.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17 (2)b;** **Good governance: Assess monitor and mitigate risks relating to the health safety and wellbeing of service users and others who may be at risk which arise from the carrying on of the regulated activity.** **Protocol and practice in the community health services for adults did not adequately protect staff who were working alone in patients homes.**

This section is primarily information for the provider

Requirement notices

The district nursing service did not use an appropriate staffing tool to calculate staffing requirements. This meant that safe staffing levels could not be reliably confirmed or audited.