

The Rotherham NHS Foundation Trust

RFR

# Community health services for adults

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RFRHC	Rotherham Community Health Centre		

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




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

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

# Summary of findings

## Ratings

### Overall rating for the service

Are services safe?	<b>Good</b> 
Are services effective?	<b>Requires improvement</b> 
Are services well-led?	<b>Requires improvement</b> 

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
Good practice	7
Areas for improvement	7

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### Detailed findings from this inspection

The five questions we ask about core services and what we found	8
Action we have told the provider to take	21

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# Summary of findings

## Overall summary

### Information about the service

Community services joined The Rotherham NHS Foundation Trust in 2011 as part of the transforming community services programme, designed to move care out of hospitals and closer to people's homes.

The trust provides both acute and community based health services to the people of Rotherham with a population of approximately 259,000. The majority of community services for adults were managed within the division of integrated medicine; however, therapy staff were managed within the clinical support division and podiatry within the surgery division.

The trust provides a range of community health services for adults, working across seven localities from the following sites; Rotherham Community Health Centre, Aston Customer Service Centre, North Anston Medical Centre, Health Village, Park Rehabilitation Centre, Rawmarsh Customer Service Centre, Maltby Joint Service Centre, Wickersley Health Centre and patients homes. Community inpatient services are provided at Oakwood Community Unit and Breathing Space.

During our visit we inspected a range of services including, the continence advisory service, community

nursing services, the care home liaison team, the integrated rapid response team, musculoskeletal clinical assessment and treatment service, the domiciliary therapy team and the falls and fracture prevention service. We also visited the care co-ordination centre.

We spoke with 40 members of staff including, community matrons, community nurses, clinical support workers, therapists, community physicians, managers, administration staff and student nurses. We observed care being provided in patient's homes. We spoke with 15 patients and looked at 10 patient records. We also held focus groups with community staff and reviewed performance information from, and about, the trust.

Community services for adults had previously been inspected as part of a comprehensive inspection in February 2015 and was rated overall as requires improvement. Safe, effective and well led were rated as requires improvement, caring and responsive were rated as good.

At this inspection, we focused on whether the services were safe, effective and well led.

# Summary of findings

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## Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Nurse Director

Head of Hospital Inspection: Amanda Stanford, CQC

The team that inspected community end of life care included CQC inspectors and community nursing specialists.

## Why we carried out this inspection

We inspected this core service as part of our responsive, follow-up inspection.

## How we carried out this inspection

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

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

# Summary of findings

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried

out an announced visit on 27 to 30 September 2016. During the visit, we talked with staff and people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

## Good practice

### Outstanding Practice

The trust was piloting a new community model of care called the perfect locality. This multiagency

/multidisciplinary team approach focused on implementing measures to avoid hospital admissions and facilitate safe discharge of patients already in hospital.

## Areas for improvement

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

#### Action the provider **MUST** take to improve:

- Must ensure that there are robust local safe systems in place to keep community staff who are lone working safe, in line with trust policy.
- Must ensure community staff are working in accordance with the Mental Capacity Act code of practice (2005).
- Must ensure that all risks for community services are included on the divisional risk register and where control measures are identified to mitigate risks, managers have assurance that control measures are effectively in place.

### Action the provider **SHOULD** take to improve:

- Should ensure that there are adequate community nursing staff to complete essential visits to patients and to limit the cancellation of non-essential visits. Teams should be flexible in working together to meet the needs of patients across the patch.
- Should ensure all policies, guidelines and procedures are regularly reviewed and kept up to date.
- Should ensure further improvement in communication between managers in the acute hospital and staff in community services, particularly community nursing.

# The Rotherham NHS Foundation Trust

## Community health services for adults

### Detailed findings from this inspection

Good 

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We carried out this inspection because when we inspected the service in February 2015, we rated safe as requires improvement. We asked the provider to make improvements following that inspection.

At this inspection, we rated community services for adults as good for safe because:

- Incident reporting was good. Staff received feedback and we saw evidence of sharing and learning from incidents.
- Compliance with mandatory training had improved in community adult services. Many areas of mandatory training exceeded the trust target of 80%. Information governance training was 93% compared with 62% last year and safeguarding adults level 2 training was 76% compared with 16% for community nursing staff at the last inspection.
- Staffing levels had improved since our last inspection; however, there were some teams under pressure in

community nursing due to vacancies and long term sickness. Safety huddles were held twice weekly to discuss staffing levels across the service and to balance risk.

- We observed good infection prevention and control practice.

However:

- Local arrangements for keeping lone workers safe were not robust. There were no regular checks in place to ensure staff were safe at the end of their working day.
- Community nursing staff told us that when their team was under pressure, it was rare for a member of staff from another team to be moved over to help. However, we witnessed a weekly staffing huddle and saw that movement of staff across the localities was undertaken by locality leads and senior community nurses. Staff told us that when staffing was low they found it difficult to complete essential visits to patients.

### Detailed findings

### Safety performance



## Are services safe?

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harm. The improvement tool focuses on four avoidable harms, falls, pressure ulcers, urinary tract infections in patients with a catheter (CUTI) and venous thromboembolism (VTE).
- We looked at the safety thermometer data for community adult services for the period September 2015 to September 2016 and found that there had been 14 falls with harm, 144 pressure ulcers (category 2 -4) and 4 new CUTIs reported within this period. Community services did not collect data on VTE.

### Incident reporting, learning and improvement.

- Staff understood their responsibilities to raise concerns and to record safety incidents. They understood how to report incidents using the electronic reporting system.
- Information supplied by the trust showed that between 1 August 2015 and 31 July 2016 there were 557 incidents reported in community services for adults. The majority of these resulted in either no harm (154) or low harm (341) with 62 resulting in moderate harm. The most prevalent reasons for moderate harm were grade three pressure ulcers (55) and grade four pressure ulcers (3).
- Serious incidents are incidents that require further investigation and reporting. All serious incidents were investigated using a Root Cause Analysis (RCA) process. Pressure ulcer review panels were held for serious incidents involving pressure ulcers grade three and above, in order to establish whether they were avoidable or unavoidable. Staff told us they were able to attend and contribute to the meeting. Feedback from the panel was shared with staff.
- We reviewed two RCA reports of serious incidents and found they were investigated thoroughly and fairly. Actions to prevent further reoccurrence and arrangements for sharing and learning were clearly documented in the report.
- Staff confirmed they received feedback from incidents and any learning was discussed at staff meetings. Learning from incidents was shared across teams in a monthly community nursing newsletter.
- There had been no never events reported for community services for adults. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

### Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with had a good awareness of the duty of candour. Staff told us they acted in accordance with the duty of candour and would apologise to patients if they caused them harm.
- Community nurses told us that they were encouraged to be open and honest when they made mistakes.
- There was a trust 'Being Open' policy, which included the process for duty of candour. This was available on the staff intranet.
- We saw evidence of duty of candour letters being sent to patients as part of the process of investigating serious incidents that resulted in patient harm.

### Safeguarding

- Community staff had a good knowledge and understanding of safeguarding and could give examples of the types of abuse they needed to look for. They were aware of their responsibilities in relation to safeguarding and knew how and when to raise a safeguarding concern.
- A registered nurse told us about when she had raised a safeguarding concern following a visit to a patient in a residential home. The nurse had been concerned about the patient's care and had completed the relevant safeguarding forms and attended a best interest meeting. We saw detailed minutes of the meeting and the action plan that had been put in place. The nurse had been kept informed during the process and the patient's safety was maintained.
- Information supplied by the trust for 2016 showed that compliance for safeguarding adults level 2 training was 76%, which was just below the trust target of 80%. Safeguarding child protection level 2 and 3 were 68% and 100% respectively against the 80% target.

### Medicines

## Are services safe?

- We observed community nursing staff administering injections to patients following careful checking of the patient's name and date of birth and prescription chart. The drug and dose were checked prior to administration.
- Temperature checks for medicines fridges in the treatment room were checked daily and were within the correct range.
- Community nursing teams and the integrated rapid response service were able to provide intravenous antibiotic therapy to patients in the community. There was a standard operating procedure for this, which was within the review date.
- Community matrons and advanced nurse practitioners were independent nurse prescribers giving patients faster access to medicines and prescription only dressings.

### Environment and equipment

- All equipment we inspected had been checked and safety tested. The next service date was recorded on equipment to ensure that they were maintained in line with manufacturers' recommendations.
- Safe procedures were in place for the disposal of waste and we saw that sharps were safely managed and disposed of in line with health and safety regulations. Sharps bins were correctly labelled and dated.
- The Rotherham Equipment and Wheelchair Service (REWS) provided pressure relieving equipment such as air mattresses and repose mattresses to patients. This equipment was ordered through the tissue viability nurse. Staff told us because they could not order the equipment directly; this sometimes led to a delay in the patient receiving the equipment. The integrated rapid response team had access to their own stock of equipment for immediate use.
- Maintenance records for equipment were logged on a central database. There was also a log of safety testing for portable appliances.

### Quality of records

- Patient records were held securely on an electronic record system. There were some paper notes kept at patient's homes but these were minimal.
- We looked at 10 community nursing patient records and found that care plans were in place and risk assessments had been thoroughly completed. Documentation was in line with professional standards.

- Information governance training levels were high at 93%, which exceeded the trust target of 80%.

### Cleanliness, infection control and hygiene

- We observed good infection prevention and control practice. Staff carried personal protective equipment (PPE) such as gloves and plastic aprons with them when visiting patients at home. Staff washed their hands and used hand gel prior to and following patient contact. We observed wounds being redressed using aseptic technique.
- Infection control and hand hygiene training compliance was 76%, which was just below the trust target of 80%.
- Community nursing teams completed hand hygiene audits every three months, which identified if staff were adhering to bare below the elbows requirements. We saw audits had been submitted for June 2016, however only five teams out of seven submitted a score. The five teams that submitted a score achieved 100%.
- Microbial decontamination audits were completed every three months by community nursing teams and were submitted for June 2016. Teams achieved 100% compliance however, only four teams out of seven submitted a score.

### Mandatory training

- Information supplied by the trust showed that compliance with mandatory training was good in community adult services. Many areas of mandatory training exceeded the trust target of 80%. Moving and handling and child protection level 3 training were at 100% however; venous thromboembolism training had the lowest compliance at 31%.
- Staff we spoke with said they were up to date with their mandatory training. They said their mandatory training record was stored on their electronic staff record and they received an email alert reminding them when their training was due. Community nursing teams had a training plan, which was monitored at monthly community nursing quality standards and governance group meetings.
- The trust provided mandatory and statutory trainings days, which covered a number of topics. Staff said this was helpful as it cut down the time it would take to travel to individual sessions. Staff also had access to e-learning.

### Lone and remote working

## Are services safe?

- There was a trust policy for managing the security of lone workers. Staff were aware of the policy. The policy stated that line managers should develop and implement a safe system of work that includes the creation of local working procedure/protocols. However, we found that most teams did not have robust local arrangements. There were some measures in place to protect staff such as personal alarms and visiting high risk patients in pairs. However, not all staff reported to their base at the end of their day or had a buddy to let them know they were safe and on their way home. There were no regular checks in place to ensure staff were safe at the end of their working day. This was identified as an issue at our last inspection and had not improved.
- The integrated rapid response team did have robust lone working arrangements. Staff had buddy arrangements in place.
- Community adult nursing teams had been reconfigured into seven locality teams in line with GP localities. Each team was managed by a locality lead and consisted of band 6 district nurse caseload holders, band 5 staff nurses, clinical support workers and a community matron.
- The Clinical Commissioning Group (CCG) had calculated nursing establishments when the seven locality model was introduced. No acuity tool had been used in this calculation.
- At the time of our inspection, staffing levels within each community adult nursing team varied. Five teams were well staffed however; two teams had a high number of vacancies and were struggling to cope with the demands of the caseload. There were also some issues with covering for staff on long term sick and maternity leave. Staff told us they tried to help each other out within the team when possible. Community nursing teams did not use bank and agency staff, although trust managers informed us there was a process in place if they were needed. Staff told us they relied on their own staff to do additional shifts to cover for the shortfall by working flexi-time. Three staff we spoke with said they had been told they could not use flexi-staff, as there was not enough money in the budget. They could work additional hours to help but would not be paid for the hours; they would have to take them back as time off in lieu.

### Assessing and responding to patient risk

- Community services for adults did not use an early warning scoring tool to detect when a patient was deteriorating and needed escalating. Staff were trained to assess a deteriorating patient using other means and took the necessary action when required to escalate the patient. Staff told us they used their own skills and knowledge to decide whether they needed to involve the GP or to call an ambulance. The teams felt well supported and felt their decision to escalate care was never challenged.
- Community staff we spoke with were aware of the key risks to patients. For example, risks of malnutrition and pressure damage to skin.
- The community nursing teams completed risk assessments for patients as part of the core patient assessment on the electronic record. Risk assessments were carried out to identify patients at risk pressures ulcers and malnutrition. Staff were aware of what action to take to protect patients from these risks. Staff were aware of how to refer patients on for specialist assessment or for the supply of additional equipment to manage these risks.
- All staff had sepsis awareness, which was taken into account when treating patients. There was no sepsis-screening tool in use in the community.
- To mitigate the risk of staff vacancies and caseload pressure, locality leads and the matron for community nursing services held a twice weekly safety huddle to discuss staffing levels across the service and to balance risk. This occurred every Monday morning to discuss staffing numbers for the week ahead and every Friday morning to plan staffing for the weekend. The weekend plan was shared with the senior on-call weekend manager. We observed a Friday safety huddle and saw that staffing and workload was discussed. One team was identified as needing additional staff and a community nurse was contacted during the meeting and asked to move to this team over the weekend period to help with their high workload.
- Despite observing the safety huddle, teams under pressure told us that it was rare for a member of staff from another team to be moved over to help. Staff told us that when staffing was low they found it difficult to complete essential visits to patients and non-essential visits would be moved on a day or two.

### Staffing levels and caseload

## Are services safe?

- Managers told us that there were plans to carry out work to establish the capacity and demand of the community nurses workload, which would take into account patient dependency however; this work had not yet started.
- The average vacancy rate for community adult services for the period April 2015 to March 2016 was 10% and the average number of whole vacancies was 21. Vacancies were being actively recruited to.
- The integrated rapid response team delivered unplanned elements of care such as crisis intervention. They were fully staffed at the time of our inspection.
- A team leader, 11 wte nurses and 10 wte administration and clerical staff, staffed the care coordination centre. At the time of our inspection, there were four staff vacancies and three staff on maternity leave. Some of these posts had been vacant since April and were now being recruited to. The team leader was working operationally to support the team when staffing levels were low.
- Two community consultant physicians supported community services and worked Monday to Friday 8.00am to 5.00pm. Outside of these times, medical cover was provided by the out of hours GP service.

### Managing anticipated risks

- The division of integrated medicine had business continuity plans in place to deal with major incidents or events that would disrupt the delivery of care.
- The care co-ordination centre had a business continuity plan in case of system failure. This plan had been tested recently when there had been an IT system failure and staff reported it worked well.
- Community nursing staff had a winter weather plan and knew what to do in the event of heavy snow or other weather, which disrupted service delivery.

# Are services effective?

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

## Summary

We carried out this inspection because when we inspected the service in February 2015, we rated effective as requires improvement. We asked the provider to make improvements following that inspection.

At this inspection, we rated community services for adults as requires improvement for effective because:

- We found that staff had a poor knowledge and understanding of the Mental Capacity Act. Staff had received training and had been given a reference card, which set out the five principles of the Mental Capacity Act. However, we found this knowledge was not embedded and staff lacked confidence in putting this into practice.
- Some policies and guidelines relating to community services were past their review date and in need of updating.

## However:

- Access to IT had improved. Staff had laptops and were able to access patient's records in the patient's home where connectivity was available.
- We saw good examples of multidisciplinary team working. The Health Village locality team pilot was a good example of care being delivered using a system wide approach.
- The trust was rolling out access to a new electronic portal, which allowed clinicians to see patient information on a number of hospital systems. Community staff told us this was very useful for planning their work.

## Detailed findings

### Evidence based care and treatment

- Community services worked with pathways based on National Institute for Health and Care Excellence (NICE) guidelines. For example, the continence team followed a pathway based on NICE guideline CG40 Urinary incontinence: the management of urinary incontinence in women.

- The falls and fracture prevention service carried out a level two multi-factorial falls risk assessment with all patients referred to the service. This was in line with NICE guideline CG161 - Falls in older people: assessing risk and prevention.
- Community nursing teams had an ongoing 'stop the pressure' campaign to reduce the number of patients developing pressure ulcers. This is in line with NICE guideline CG179 Pressure ulcers: prevention and management.
- Clinical pathways based on national guidelines were in place at the care coordination centre for staff to follow. For example, there were pathways for sepsis and deep vein thrombosis. If necessary staff could escalate the patient to specialist services or access admission.
- The podiatry service had completed a form to measure compliance against NICE guideline NG19 - Diabetic foot problems: prevention and management. We saw an action plan to address areas where the service was not fully compliant.
- There was a programme of clinical audit projects for community adult services. Staff could tell us about local audits they were involved in. Quarterly audits were carried out by community nursing teams, which included documentation and electronic records, pressure ulcers, catheter care, hand hygiene and microbial decontamination.
- We observed trust policies and procedures on the trust intranet and found that most were up to date. However, we found some were out of date. For example, the review date for the 'Procedure for bladder catheterisation' was 2012.

### Pain relief

- Pain was routinely assessed by community nurses as part of the new patient assessment and recorded on pain assessment charts.
- The domiciliary therapy team monitored patients levels of pain using a pain score chart.

### Nutrition and hydration

- We saw that community nursing teams used a nationally recognised risk assessment tool, the

## Are services effective?

Malnutrition Universal Screening Tool (MUST) to assess patients at risk of malnutrition. We found this was completed in line with best practice in the records we looked at.

- Patients found to be at risk of malnutrition, and those requiring additional support with nutrition and hydration were referred to the dietician.

### Technology and telemedicine

- Community staff had good access to IT equipment and could access patient electronic records. Staff told us connectivity was poor in some areas of Rotherham, which meant they could not always access patient's records at the point of care delivery. A protocol was in place for staff to follow when they were unable to connect to the system. The management team were looking to develop an offline solution to this problem.
- Telehealth was used to monitor and manage patients with heart failure. Patients measured their weight and blood pressure and entered it into the telehealth programme on a tablet computer. This information was then received at the care co-ordination centre and any abnormal results were escalated to the heart failure specialist nurses who would contact the patient.

### Patient outcomes

- There were agreed outcome measures for the integrated locality pilot. These were related to a reduction in hospital admissions and reduced length of stay. The pilot had been running for two months at the time of our inspection therefore outcome data was not available. However, staff were able to give us examples of how intervention of the new team had positive outcomes for patients.
- The domiciliary therapy team worked with patients using goals and measure of improvement indicators based on activities of daily living. They also used pain scores to measure patient outcomes and the effectiveness of their interventions.
- Therapists in the musculoskeletal clinical assessment and treatment service used the EQ-5D-5L tool to measure patient outcomes. Patients completed the measure at the start and end of treatment. The tool measured five dimensions of health: mobility, ability to

self-care, ability to undertake usual activities, pain and discomfort, and anxiety and depression. The service had a key performance indicator of 80% improvement, set by commissioners.

- The care homes liaison team had 13 key performance indicators to meet relating to patient falls, hospital re-admissions, length of stay, emergency department attendances and admissions. A monthly performance report was submitted to senior managers and commissioners. We saw that the team were on target to achieve 10 indicators and off target for three indicators.
- The care coordination centre had key performance indicators for time taken to answer the phone and abandoned calls. The target for answering a call was 15 seconds.

### Competent staff

- Community matrons had monthly meetings which incorporated clinical supervision with the clinical director. Issues such as prescribing would be discussed.
- Advanced nurse practitioners received medical supervision with the community physician once a month. They discussed complex cases they had dealt with and talked through their clinical rationale and decision making process. On a day to day basis, their support came from GPs who covered the care homes.
- Physiotherapy staff in the musculoskeletal clinical assessment and treatment service had weekly one to one supervision and participated in peer supervision.
- The overall compliance rate for appraisals in community adults during the period April 2015 to March 2016 was high at 84%. This was an improvement on the previous year when 73% of staff had completed an appraisal. Staff we spoke with had completed their appraisals with their line manager and had a development plan. Most staff said they found the appraisal useful.
- Newly recruited nurses were offered the opportunity to join a 12 month programme of development called the compass programme. Nurses on the programme were able rotate into medicine, surgery and community nursing, spending three months in each and completed a leadership module. The programme was designed to improve standards and nurture talent. We met two nurses during our inspection who were taking part in this programme.



## Are services effective?

- Band 5 community nurses we spoke with told us when they joined the trust they had a four week induction programme and worked alongside another more experienced nurse, which they found very helpful. They also completed training and competencies.
- The trust had introduced a pre-course for band 5 community nurses who wanted to apply for district nursing training. The course aimed to develop competencies and test suitability for district nurse training. Staff told us the funding for the programme was no longer available however, some of the individual study days were still offered to staff.
- The continence team provided catheter care training, bladder and bowel training and continence assessment training to the community staff. There were plans to start regular meetings with continence link nurses in the community nursing teams.
- Staff at the care coordination centre were able to contact medical registrars for clinical support and advice on escalation of a patient.
- Community nursing staff told us they had been well supported in revalidation.
- Staff told us access to training had improved although one team had recently cancelled staff training due to workload pressure and needing to prioritise patient care.
- Community services supported student nurses and therapists on placement. We spoke to four student nurses during the inspection who told us they felt welcomed and supported.
- The falls and fracture prevention service was delivered by a specialist multi-disciplinary team comprising occupational therapists, advanced nurse practitioner, support workers and administrators. The team worked jointly with the local council to provide a 12 week education and exercise programme to patients.
- Community nursing teams had good support from tissue viability nurses and carried out joint visits to patients when required.
- The continence team told us they had good links with the multi-disciplinary team such as the spinal injury team and the specialist nurse for multiple sclerosis.
- The Health Village locality team were the pilot site to test a new model of care involving a system wide approach. This involved a multidisciplinary team of GPs, a community physician, community matrons, district nursing, mental health professionals, therapists, social care workers and the voluntary sector. All agencies were co-located in the same building in order to promote integrated working. A multidisciplinary team meeting was held every week. Staff told us communication between professional groups had improved as a result of the pilot.

### Referral, transfer, discharge and transition

#### Multi-disciplinary working and coordinated care pathways

- Community matrons worked closely with GPs to care for patients with long term conditions in their own homes in order to prevent hospital admissions. They attended long term conditions meetings which were held once a month at GP surgeries. GPs, social workers, voluntary sector workers and the palliative care nurse attended to discuss the case management of complex patients.
- The care homes liaison team was a multidisciplinary team of nurses, advanced nurse practitioners, physiotherapists, speech and language therapists, occupational therapists and generic support workers. A representative from the team attended weekly meetings with the transition of care team at Rotherham General Hospital to assist with discharge arrangements for care home patients.
- The care co-ordination centre managed referrals to community nursing services through a single point of access. The centre also supported the case management of patients identified by community matrons across all seven localities, in order to prevent unnecessary admissions.
- Community nursing staff told us that sometimes the referral information they received from the care co-ordination centre was incomplete and they needed to contact them for more details. However, they said their relationship with staff at the centre was good and they were working with them to improve the quality of the referrals.
- Some community nursing teams had a nurse allocated to triage duties who would sort out inappropriate referrals and allocate incoming referrals to the team.
- The musculoskeletal clinical assessment and treatment service received referrals from GPs by fax, post, or electronically. Patients could be booked into an appointment directly using choose and book.

## Are services effective?

- The falls and fracture prevention service received referrals from GPs, Age UK, the emergency department, the fracture clinic. Patients identified as being at high risk of falls, or those who had recently fallen and had a non-hip fracture were referred to the service.
- The continence team could refer patients directly to consultants if needed.

### Access to information

- Community staff had laptops, which allowed them to access and input information onto patients' records at any location. In most cases, staff told us that they could access patient records in the patient's home as well as at their office base. The exception to this was when they were visiting a patient in an area with poor connectivity. A protocol was in place for staff to follow when they were unable to connect to the system.
- The trust was rolling out access to a new electronic portal, which allowed clinicians to see patient information on a number of hospital systems on their mobiles, tablets and desktops. Community matrons and nurses told us this was useful for planning their visits and for seeing what interventions their patients had in hospital prior to discharge back into their care. The trust had received a nomination for an informatics award for this work.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Although staff told us they had received training, we found knowledge and understanding of the Mental Capacity Act was poor amongst most staff.
- Staff had been given a reference card, which set out the five principles of the Mental Capacity Act however; we found this knowledge was not embedded and staff lacked confidence in putting this into practice. Staff were not clear on how to carry out a mental capacity assessment.
- Community nurses we spoke with said if they thought a patient was confused they would refer them to their GP.
- There was a tick box within the patients electronic records to record whether a patient had capacity however, some staff we spoke to were not aware of this.
- We observed all staff gaining verbal consent prior to providing care.
- Dementia awareness training compliance was 92% which exceeded the trust target of 66%



## Are services well-led?

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

### Summary

We carried out this inspection because when we inspected the service in February 2015, we rated well-led as requires improvement. We asked the provider to make improvements following that inspection.

At this inspection, we found community services for adults to be requires improvement for well led because;

- Senior managers in the division of integrated medicine had a vision to develop community services and articulated this clearly to us during the inspection. However, not all staff working in community were aware of the vision for community services or the locality pilot, which was underway.
- Risks for community services were included on the divisional risk register and control measures had been identified however, we found in practice the measures were not in place effectively and the management team were not aware of this. Senior managers told us they were aware of issues around capacity and demand which posed a risk to the success of the new locality pilot. However, we did not see this risk reflected on the divisional risk register.
- Although there was an improvement in staff morale, staff still said they did not feel valued or that their skills were being recognised in community services.
- Communication between managers in the acute and staff in community services had improved but further improvement was needed with community staff who still felt disconnected. Community nursing staff we spoke with said they felt the link between them and the senior management team had deteriorated since the deputy head of nursing had left.

However:

- Staff felt well supported by their line managers. Community nurses told us they liked the locality model and felt well managed by their locality leads.

- Staff enjoyed their work and were patient centred in their approach. Staff we spoke with said they were proud of their services and passionate about patient care.

### Detailed findings

#### Leadership of this service

- Community services for adults sat within the division of integrated medicine, which was led by the divisional director, general manager and head of nursing. Operationally the deputy general manager took a lead on community adult services and there was a deputy head of nursing for community however, this post was vacant at the time of our inspection. A matron for community services provided line management to the locality team leaders, care homes liaison team and integrated rapid response team.
- There was a separate leadership structure for therapists and dietetics, which sat within the clinical support services division. Clinical leads within this service spoke highly of their line managers.
- Since our last visit, a tier of management had been added to the community nursing structure. There were seven locality managers, one post was vacant at the time of our inspection and cover was being provided by two other locality managers. Staff told us they liked the new locality model and felt well supported by their line managers.
- Locality managers told us that previously as budget holders they had been able to approve staff working additional hours to cover vacancies however, this decision now needed to be escalated to the head of nursing. They felt they had lost some responsibility and accountability and that this led to delays in decision making.
- Staff told us that since the deputy head of nursing had left they felt their links with the senior management team were poor. This was a common view from staff attending the community nurses focus group. Two

## Are services well-led?

community matrons told us they were being seconded to cover this role on a temporary basis as a job share and would be starting soon. However, they were vague on what the role involved.

- Due to staff vacancies and maternity leave, the lead nurse of the care coordination centre was working operationally to support the team. We were told this was affecting time to complete audits and other management duties.
- The locality pilot had a dedicated project manager. Clinical leadership was provided by the divisional director. The Chief Operating Officer attended weekly meetings to discuss the project plan. The project manager told us that although senior managers were sighted on the priorities, resources and support needed for the project to succeed, no actions had been put forward. Teams were working well together however, the aim to fully integrate the teams was challenging because teams had separate line managers.
- Staff said they rarely saw senior managers from the acute side of the trust but spoke highly of the Chief Nurse and said they were often seen in the community.

### Service vision and strategy

- The trust had recently refreshed their vision and values. The values were ambitious, caring and together. The vision was to transform community based healthcare in Rotherham with local teams from health and social care working together in the community to provide care closer to home.
- Community services strategy was to develop and roll out an integrated community locality model to deliver this transformation in community by the end of 2017. A pilot of the integrated locality model commenced in the Health Village locality in July 2016. The strategy included advising patients on self-care and providing wellbeing events to keep people healthy.

### Governance, risk management and quality measurement

- Risks for community services were included on the divisional risk register. Risks we identified during our visit were on the register such as lone working and insufficient staffing in some of the community nursing teams. Control measures were identified however, we found in practice the measures were not in place effectively and the management team were not aware of this.

- Lone working for community staff was identified on the risk register however, managers had not implemented safe systems of work in some teams, which left staff vulnerable. Managers could therefore not be assured that they were keeping their staff safe.
- Senior managers told us they were aware of issues around capacity and demand which posed a risk to the success of the new locality pilot. However, we did not see this risk reflected on the divisional risk register. They told us that there were ongoing discussions with commissioners to resolve issues but no plans were in place to mitigate the risk.
- Community adult services held monthly quality standards and governance meetings. This was attended by the lead matron for community, locality leads and a governance coordinator. We saw from the minutes that new and existing risks were reviewed at every meeting and patient safety issues such as the safety thermometer, incidents and pressure ulcers were discussed.
- Risks, which could not be finally approved for the directorate register, or those scoring higher than 16 would be escalated to the corporate risk register. Those scoring 16 or above would be reviewed on a monthly basis by the trust management committee.
- We saw that quality assurance data was collated for the integrated medical division through a performance dashboard.
- Representatives from the clinical commissioning group carried out a programme of clinical visits across the integrated trust. Internal quality walkabouts, which included governors and non-executive directors as well as trust staff, also took place on a monthly basis. Community staff said that walkabouts had taken place in community however; they did not feel enough time was spent with them to get a true picture of their services.
- The continence team leader met with the deputy general manager every two months to discuss service development and issues of concern.
- A matron took the lead on quality and governance for the division of integrated medicine.

### Culture within this service

- Staff enjoyed their work and were patient centred in their approach. Staff we spoke with said they were passionate about patient care.

## Are services well-led?

- Although there was good teamwork, some teams were struggling with their workload and did not feel they were being supported to manage this, which was causing them to feel stressed. They told us that giving good patient care was important to them and they did not always feel they had the time to do this.
- Staff who knew about the new locality pilot were positive and hoped this would be a good opportunity to improve services for patients. Managers recognised that some staff working in the pilot were struggling with new roles and new ways of working.
- Staff told us they were proud of the services they provided to patients and the quality of care they delivered.

### Public engagement

- The trust held a stakeholder event to launch the pilot of the 'Perfect Locality Team'. This was attended by other agencies including the police, fire service, the local hospice and local authority council.
- Quality assurance walkabouts were conducted in the acute and community settings to obtain feedback from patients and carers. A new process has been implemented for community services in that two out of the six monthly reviews focused entirely on community. The results of the walkabouts were fed back to staff and discussed at the patient experience group.
- There were expert patient groups for heart disease and diabetes and a user group for lung fibrosis. The management team acknowledged that there was little engagement with carers and they needed to do further work on this.
- Community adult services participated in the Friends and Family Test.

### Staff engagement

- Although morale had improved since our last visit, community nursing teams told us they still did not feel valued or that their skills were being recognised.
- Therapy staff we spoke with told us that they did not feel part of the acute trust. They acknowledged the management team were trying to involve them in their plans but there had not been much change since the last inspection.
- Communication between managers in the acute and staff in community services had improved but further improvement was needed with community staff who

still felt disconnected. Community nursing staff we spoke with said they felt the link between them and the senior management team had deteriorated since the deputy head of nursing had left.

- Not all community staff we spoke with were aware of the locality pilot and the vision for community services.
- Staff in the continence team told us that they felt integration had improved between community services and the acute hospital services however; they thought that newsletters were still too focused on acute services.
- The divisional management team acknowledged that communication with remote teams was a challenge and had started using alternative methods such as text messages and social media.
- Staff we spoke with were proud of their teams and said they worked closely together and had good communication and support.
- Staff told us they had been involved in 'drop in' sessions for the development of the new trust vision and values.
- There was a monthly team brief delivered by the executive team which all staff were invited to attend. Previously this had been held at a venue within the hospital however in response to a request from community staff it was now delivered at the hospital and a community venue. Staff told us this was more accessible however, they found that most information was related to acute hospital targets with a small mention of what was happening in community at the end. They said they had become dis-engaged with the team brief because of this. Work was ongoing to develop more community orientated material in the team brief by the executive team.
- The trust held an annual 'proud' awards ceremony to recognise exceptional staff and services. Staff in community adult services had been nominated and received awards at the last award ceremony.
- For the period April 2015 to March 2016 the average sickness rate for staff in community adult services was 4%. This was the same as the previous year. The average turnover rate for this period was 10.8%

### Innovation, improvement and sustainability

- The trust was piloting a new community model of care called the perfect locality. This multi-agency/multidisciplinary team approach focused on implementing measures to avoid hospital admissions

## Are services well-led?

and facilitate safe discharge of patients already in hospital. This project was still in the early stages with issues being worked through. If successful, this project would be rolled out to all seven localities.

- Access to information had improved with a new in house electronic portal. The portal allowed clinicians to see patient information on a number of hospital

systems on their mobiles, tablets and desktops. Community matrons and nurses told us this was useful for planning their visits and for seeing what interventions their patients had in hospital prior to discharge back into their care. The trust had received a nomination for an award for this work.

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the regulation was not being met:

Knowledge and understanding of the Mental Capacity Act was poor amongst most staff.

Staff were not clear on how to carry out a mental capacity assessment.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the regulation was not being met:

Risks we identified during our visit were on the register such as lone working and insufficient staffing in some of the community nursing teams. Control measures were identified however, we found in practice the measures were not in place effectively and the management team were not aware of this.