Northumbria Healthcare NHS Foundation Trust

RTF

Community health services for adults

Quality Report

Northumbria Healthcare NHS Foundation Trust
Tel: 0344 811 8111
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Date of inspection visit: 9-13 November 2015
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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)
RTFFS	North Tyneside General Hospital	Foundry House, The Oval, Bedlington, NE22 5HS	
RTFFS	North Tyneside General Hospital	Wansbeck General Hospital, Woodhorn Lane, NE63 9JJ	
RTFFS	North Tyneside General Hospital	Morpeth NHS Centre, Morpeth, NE63 1JX	
RTFFS	North Tyneside General Hospital	Northumbria Specialist Care Hospital, Cramlington, NE23 6NZ	
RTFFS	North Tyneside General Hospital	Wallsend Health Centre, Wallsend, NE28 7PB	
RTFFS	North Tyneside General Hospital	Shiremoor Resource Centre, Shiremoor, Whitley Bay, NE27 0HJ	
RTFFS	North Tyneside General Hospital	Blyth Health Centre, Thurston Street, Blyth, NE24 1DX	
RTFFS	North Tyneside General Hospital	Nursery Park Health Centre, Ashington, NE63 0HP	
RTFFS	North Tyneside General Hospital	Lintonville Health Centre, Ashington, NE63 9UT	
RTFFS	North Tyneside General Hospital	Bondgate surgery, Alnwick, NE66 2NL	
RTFFS	North Tyneside General Hospital	Corbridge Health Centre, Corbridge, NE45 5LG	

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

Summary of findings

Ratings

Overall rating for the service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

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Overall summary

Overall rating for this core service Outstanding

We rated community adult services as outstanding because:

National guidance, the National Institute of Health and Care Excellence (NICE) and professional bodies were complied with and that staff showed awareness of relevant guidance in their work. Staff were actively engaged in activities to monitor and improve quality and outcomes. For example, the tissue viability service (TVS) used the SSKIN bundle, this was a five step model to reduce incidents of pressure ulcers and endorsed by NHS England. The service had gone further in pioneering their own pressure ulcer and skin integrity 'aide memoire' for staff to assist in identifying patients at risk of developing pressure ulcers. This had resulted in the trust moving from being a national outlier for pressure ulcer care to consistently performing better than the national average. Quality of care was monitored through audits, which informed the development of local guidance and practice. We found that patients could access all professionals relevant to their care through a system of truly integrated multi-disciplinary teams; and that patients' care was co-ordinated and managed. There were systems to gain people's consent prior to care and treatment. Where patients lacked the capacity to give consent, there were arrangements to ensure that staff acted in accordance with their legal obligations. There were robust systems to ensure professional staff remained registered with the relevant professional body.

Patients and carers we spoke with were overwhelmingly positive about their experience of care and treatment, and feedback gathered by the organisation showed high levels of satisfaction. Words and phrases such as "tremendous," "cheerful and considerate," "extremely happy with the care," were used extensively in their feedback. We viewed the Community Services Business Unit (CSBU) Friends and Family Test (FFT) results November 2015; 99% of patients said they were treated with dignity and respect. We reviewed results from the FFT for the period July – September 2015 for 24 Community Adult Services Teams. The average score for people who responded that they would be likely to recommend community services was 99%. We observed all staff responding to people with kindness and compassion. Patients told us they were treated with dignity and respect, and that they were involved in the planning and delivery of their care to the extent they wished to be. Staff were prepared to and did go the 'extra mile' for patients.

The involvement of other organisations and the local community was integral to how services were planned and ensured that services meet people's needs. We found that community adult services had a model of integrated community teams across health and social care to ensure people received truly joined up working that was responsive to patients' individual needs. There was a focus of providing services close to where people lived and at times that were convenient to them. There was provision to ensure that essential services were available out-of-hours, and there were no major issues with waiting lists.

There was a clear vision and values that were shared by staff and demonstrated in their work. There was a clear articulation of the strategic direction for the service and staff felt engaged with the strategy. Consideration was given to ensure that developments were sustainable. We found evidence of innovative practice and research including partnership working with industry. The leadership drove continuous improvement and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. There were systems to ensure good governance and monitoring of standards and performance. There was an effective escalation and cascading of information from the board to front-line workers, and vice-versa. We found that there was a positive culture, with staff and managers feeling proud of their work and achievements and speaking well of their colleagues and the organisation.

We found that community adult services (CAS) achieved a good standard of safety. This was because there were robust methods of reporting, investigating and learning from incidents and near misses that were well understood by staff and embedded in their daily work. There were plans to deal with major incident or events that would disrupt the delivery of care. We saw evidence that CAS staff were making appropriate adult safeguarding referrals. There were processes and systems

Summary of findings

that protected patients from the risk of infection, and the risks associated with equipment used in their care and treatment. There were safe systems of medicines management. Records were accurate, comprehensive and current, and supported the delivery of safe care. We saw that between 85% and 100% of mandatory training had been completed across CAS against a trust target of 85%. Staffing numbers were reviewed, an active recruitment programme was in progress and arrangements to ensure any staffing shortfalls were managed on an on-going basis to minimise the impact on patients.

Summary of findings

Background to the service

Information about the service

Community adult services in Northumbria and North Tyneside are provided by Northumbria NHS Foundation Trust, a combined acute and community services trust. Services were provided in patients' homes or at a variety of health centres and medical centres. Community services for adults included tissue viability services, cardiology, podiatry, speech and language therapy (SALT) and a range of other services including:

- The Immediate Response Team (IRT) offers a range of integrated services to support care closer to home for patients and avoid unnecessary hospital admissions. The fully integrated team of community health and social care staff aims to make contact with a person in need within two hours of the first call for assistance, and can provide equipment to help someone move around their house, arrange emergency short term care support to enable them to remain at home, and regain their confidence and independence.
- The Short Term Support Service (STSS) provides help in people's homes. People referred to STSS were assigned a key worker who worked with people to develop a care plan. This could include one of the following: personal care and support to help people to be more independent; rehabilitation following a serious accident or illness including physiotherapy; speech therapy and occupational therapy; equipment including walking aids and adaptations in the home, such as stair lifts; shower seats; alarm and door entry systems; end of life care, including nursing care at home: emotional and psychological support. The STSS service was available for up to six weeks but sometimes people only need a single visit, for example, from an occupational therapist to organize getting equipment to help them live at home.
- The Hospital 2 Home (H2H) team is made up of multi-skilled health professionals including community nurses, social workers, occupational and physiotherapists, care managers, discharge nurses, support planners and care coordinators. H2H was a 24 hour, seven-day service that ensured timely discharge for people from hospital.
- District nursing services (DN) in Morpeth NHS Centre, Wallsend Health Centre, Shiremoor Resource Centre, Blyth Health Centre, Bedlington Health Centre, Lintonville Health Centre, and Corbridge Health Centre provide care predominantly to housebound patients, but also in clinics in GP settings. A qualified district nurse (a registered nurse with additional qualifications) leads the district nursing teams.
- Community matrons also operate within the community services for adults. Community matrons are a team of nurses working in Northumbria and North Tyneside who provide care for adults with complex long-term conditions, such as: diabetes, respiratory disease, or heart disease. Community matrons visit people in their own homes and develop personalised care plans. Community matrons co-ordinate care with other health and social care professionals. By doing this they can prevent unnecessary admission or attendance at hospital and they work with GP's and the acute hospital to support discharge home.
- Community therapies which include: speech and language therapists (SALT); physiotherapists; and occupational therapists; and podiatry.

We visited a sample of Community Adult Services (CAS) on 9-13 November 2015. We talked with 30 people who use services and four carers. We spoke with eight managers, and 20 registered and three unregistered nursing staff. We observed how people were being cared for in clinics and in their own homes and reviewed care or treatment records of people who use services. We visited the community wheelchair services and the following locations:

- Foundry House, Bedlington,
- Wansbeck General Hospital
- Morpeth NHS Centre, Morpeth,
- Northumbrian Specialist Care Hospital, Cramlington,
- Wallsend Health Centre, Wallsend
- Shiremoor Resource Centre, Whitley Bay
- Blyth Health Centre, Blyth
- Nursery Park Health Centre, Ashington
- Lintonville Health Centre, Ashington
- Bondgate Surgery, Alnwick

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- Corbridge Health Centre, Corbridge

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE**,** Consultant Physician.

Team Leader: Amanda Stanford, Head of Hospitals Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Health Visitors, District Nurses, Physiotherapists, Occupational Therapists, Community Matrons, Dentist and Expert by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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 the announced visit from 09 to 13 November 2015.

What people who use the provider say

- Patients and carers we spoke with were overwhelmingly positive about the care and treatment they received from Community Adult Services. Words and phrases such as "tremendous," "cheerful and considerate," happy with the care," were used extensively in their feedback.
- We viewed the Community Services Business Unit (CSBU) Friends and Family Test (FFT) results dated November 2015, 99% of patients said they were treated with dignity and respect. We reviewed results from the FFT for the period July – September 2015 for 24 Community Adult Services Teams. The average score for people who responded that they would be likely to recommend the service was 99%.
- The October 2015 'Integrated Governance and Performance' meeting report carried the results from the 'Two minutes of your time' patient survey. The survey demonstrated that 3492 community services patients responded to the survey in the previous three months and 99% of patients responded that they were treated with dignity and respect.
- In the Community Services Business Unit (CSBU) Friends and Family Test (FFT) results for July - September 2015, 97% of patients said they received the information they needed. We reviewed results from the FFT for 24 Community Adult Services Teams. The average score for people who responded that they would be likely to recommend the service was 99%.

Summary of findings

Good practice

- The immediate response team (IRT) provided urgent support for people in a time of crisis. The IRT team joint worked across adult social care between Northumbria Healthcare NHS Foundation Trust and the local authority. The partnership working had developed a range of integrated services to support care closer to home for patients and avoid unnecessary hospital admissions. The fully integrated team of community health and social care staff aim to make contact with the person in need within two hours of the first call for assistance, and could provide equipment to help people move around their house, arrange emergency short term care support to enable them to remain at home, and help people to regain their confidence and independence.
- Community Adult Services ran a free of charge 'Inspired Carer Masterclass' for staff from local residential care and nursing homes to improve care for patients receiving care in care homes. This was a one day course for care home managers and staff. The training covered dementia care, falls prevention, infection prevention and control, swallowing assessment, depression, skin integrity, and supporting families. The training was delivered by a variety of CAS staff including community matrons, SALT, and physiotherapists.
- Community Adult Services had specialist community research nurses that were funded by the trust's research and development team. For example, the Tissue Viability Service (TVS) research nurse was involved in a clinical trials study with a university into pressure ulcer mattresses. The TVS service had also conducted research for a large corporate company who specialised in providing products for advanced wound management.
- The TVS had introduced a SSKIN bundle and 'aide memoire' for pressure ulcer care. This had resulted in the trust moving from being a national outlier in pressure ulcer care, to performing better than the national average.

Northumbria Healthcare 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 rated safe as good because:

We found that community adult services (CAS) achieved a good standard of safety. This was because there were robust methods of reporting, investigating and learning from incidents and near misses that were well understood by staff and embedded in their daily work. There were plans to deal with major incident or events that would disrupt the delivery of care. We saw evidence that CAS staff were making appropriate adult safeguarding referrals. Staff we spoke with were aware of the trust adult safeguarding leads and knew how to contact them. The leads were described by staff as being helpful and supportive with safeguarding issues. We saw that there were processes and systems that protected patients from the risk of infection, and the risks associated with equipment used in their care and treatment. There were safe systems of medicines management. Records were accurate, comprehensive and current, and supported the delivery of safe care. We saw that between 85% and 100% of mandatory training had been completed across CAS against a trust target of 85%.

Staffing numbers were reviewed, an active recruitment programme was in progress and arrangements to ensure any staffing shortfalls were managed on an on-going basis to minimise the impact on patients.

Staff were actively engaged in activities to monitor and improve quality and outcomes. For example, the tissue viability service (TVS) used the SSKIN bundle, this was a five step model to reduce incidents of pressure ulcers and endorsed by NHS England. The service had gone further in pioneering their own pressure ulcer and skin integrity 'aide memoire' for staff to assist in identifying patients at risk of developing pressure ulcers. This had resulted in the trust moving from being a national outlier for pressure ulcer care to consistently performing better than the national average. We found that patients could access all professionals relevant to their care through a system of truly integrated multi-disciplinary teams; and that patients' care was co-ordinated and managed well. Staff were encouraged and supported by the organisation to gain additional qualifications relevant to their role, and staff in senior positions held appropriate qualifications.

Detailed findings

Good

Are services safe?

Safety performance

- The community adult's service had a good level of safety performance over time. CAS participated in the National Safety Thermometer programme; this is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. All district nursing services participated in submitting information to the NHS Safety Thermometer. We saw that Safety Thermometer monthly results were prominently displayed in all the local offices we visited.
- Data submitted since April 2015 showed the number of community acquired pressure ulcers over the period April 2015 to August 2015 included 32 unavoidable grade 2; and one unavoidable grade 4 pressure ulcers reported in the period. Community services reported no avoidable grade 3 or grade 4 pressure ulcers in the same period.
- The community adult's service used service dashboards to monitor harm free care. We viewed the dashboard performance report from June 2015. This benchmarked the service performance against the trust's health care targets. We saw that in most instances the service was exceeding the trust's targets. For example, the trust's quality and safety scorecard indicated that to reduce the incidence of sepsis the trust required that 75% of patients with urethral catheters should have the justification for the use of a catheter recorded. The community adult's service had exceeded the target with 97% of patients in Northumberland and 88% of patients in North Tyneside having it recorded.

Incident reporting, learning and improvement

- Incidents were reported using an electronic reporting system which also provided reports for managers on reporting activity and incidents. All staff we spoke with were aware of the system and told us they were confident in its use. Staff indicated they felt empowered to report any type of safety incident or near miss that might affect patient safety.
- We saw records were kept regarding all safety incidents and near misses reported in community adult services. These included details of the incident and how and why it occurred. We saw that actions to mitigate against the risk of recurrence had been formulated and noted that these were appropriate to the incident described.
- A total of 351 incidents were reported between March 2015 and June 2015. The majority (97%) of these were classified as either low or no harm. The community adult's service used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately.
- We reviewed a sample of investigation reports submitted by the service. Root cause analysis was completed as part of the investigation of incidents. Root cause analyses identified learning from incidents this was shared across teams. We reviewed the root cause analysis of an incident which occurred in February 2015. We saw that there had been a thorough investigation and analysis of the incident. Learning points had been identified and actions were underway to address those care issues.
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within community services.
- A standard agenda was used for staff team meetings and learning from incidents was discussed and shared with staff at those meetings. We saw the notes of team meetings that demonstrated that incidents, their analysis, lessons learned and outcomes were discussed and communicated to staff. Staff we spoke with told us the discussion and consideration of safety events was frequently part of their routine.
- All patients with pressure ulcers were recorded on the electronic reporting system. Staff told us the system was used to monitor incidence of pressure ulcers across teams.
- Safety alerts were sent to clinical leads by email. The alerts were reviewed by clinical leads for their relevance and shared with staff by email or discussed at team meetings. Safety alerts were available to staff in team folders on the trust's shared computer drive.

Safeguarding

- The trust's director of nursing was the executive lead for safeguarding adults and children. Community adult services had a named lead district nurse specialist for adult safeguarding.
- We saw evidence that CAS staff were making appropriate adult safeguarding referrals. Staff we spoke

with were aware of the trust adult safeguarding leads and knew how to contact them. The leads were described by staff as being helpful and supportive with safeguarding issues.

- The trust had an up to date adult safeguarding policy that was issued in September 2014 and due to be reviewed in June 2017. Staff we spoke with were able to explain their understanding of the policy and how they used this as part of their practice.
- Staff received training in adult safeguarding as part of their mandatory training. All community staff received safeguarding adult's level one training. Staff received training updates at a level appropriate to their area of work. For example, district nursing staff and podiatrists received level two training including safeguarding children and young people. We reviewed evidence that compliance with mandatory training was 100% against a trust target of 85% in most community teams. None of the community teams' mandatory training fell below the trust's target. This meant there was assurance that staff had up to date safeguarding training and knew how to respond to safeguarding concerns.
- Staff we spoke with were able to describe the categories of abuse and how they would report potential safeguarding issues. Issues were reported to the safeguarding lead for further investigation. Learning from safeguarding investigations was shared at team meetings and across the service where appropriate.
- Patients we spoke with told us they felt safe and expressed confidence in the staff that worked with them.
- Information about safeguarding for patients in the community was included in patients home based records, for example, contact details for the trust's safeguarding team. The trust's website included contact details for the safeguarding adults' team and local authority safeguarding teams as well as advice for people who use services and their families.

Medicines

- Medicines were prescribed, supplied, stored, and administered appropriately.
- Training in the administration of medicines was undertaken by appropriate staff groups. All case holding district nurses were trained in community formulary. Community matrons were trained in prescribing and advanced practice clinical skills.
- We reviewed eight medicine administration records and found these were up to date and in order. Medication errors were reported as incidents and were followed up to identify learning.
- Controlled drugs (CD) were handled appropriately, with the involvement of the GP as necessary. The CAS service had standard operating procedures to guide staff in CD administration, this included clear guidance. Staff undertook CD risk assessments to assess the risks to people, including allergy risks and the risk of overdose. Patients' assessed as medium or high risk, or patients' having complex syringe drivers set up, would require two nurses to be present.
- The trust had a clear policy and guidance for staff on the management of homecare medicines, this included all staff handling medicines in the home being trained to an appropriate standard.

Environment and equipment

- We found there were systems to ensure staff were trained and competent to use the equipment used in their daily work. Mandatory training records dated November 2015 showed that all grades of CAS staff had met the trust's 85% target for health and safety training. For example, across all CAS sites 100% of administrative staff and social care review staff, and 88% of community nursing staff were up to date with health and safety training.
- Equipment had records were identifiable and traceable with service dates recorded. Syringe drivers were traceable and that their last and next service dates were recorded to ensure that they were maintained in line with manufacturers' recommendations. We noted that these dates for servicing were up to date.
- We saw clinical and domestic waste was separated and waste bins were covered and operated by foot pedal. We observed contaminated clinical waste awaiting collection at the Nursery Park Health Centre in Ashington was stored securely in a locked in a store. This ensured there could be no unauthorised access to hazardous waste materials.
- We found that the conditions of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 were being met. 'Sharps' waste was disposed of in appropriate receptacles which were properly labelled.

Quality of records

Good

Are services safe?

- The CAS integrated working agenda meant that staff had been trained in the NHS SystmOne, a clinical computer system used by healthcare professionals in primary care and the local authority's SWIFT electronic records system. This meant NHS staff could have access to information on people's social care needs without the delays caused by having to request information directly from the local authority. It also meant that NHS staff could record actions they had taken to address a person's needs on the local authority system, resulting in people receiving a seamless service.
- Mandatory training records dated November 2015 recorded that 100% of staff working in CAS had completed up-to date mandatory training in 'information governance', this was above the trust target of 95%.
- We saw CAS were in the process of rolling out mobile working across community adult services. Care plan records were kept in people's homes. The risk that people's care plan records may not be congruent with their electronic record was mitigated due to CAS having introduced tablet computers and mobile working. Staff told us this enabled them to record on people's electronic record in "real time." District nursing staff at Alnwick told us mobile working had made the team feel less isolated and much more part of the CAS team. Staff told us mobile working had resulted in improved information sharing between CAS teams as well as staff having access to the most up to date information for people who lived in rural areas.

Cleanliness, infection control and hygiene

- CAS were compliant with the "Code of Practice on the prevention and control of infections and related guidance" issued by the Department of Health in 2010.
- Mandatory training records dated November 2015 recorded that 100% of eligible staff had completed mandatory infection prevention and control training, which included hand hygiene, against the trust target of 85%.
- The trust had completed a trust wide audit of compliance with Methicillin Resistant Staphylococcus aureus (MRSA) policy in December 2014. The audit identified there had been no reported cases of MRSA detected by CAS in the previous 12 months.
- We saw that premises where patients were treated were clean and hygienic. We saw cleaning schedules that clearly set out how and when premises and equipment should be cleaned. Patients we spoke with did not raise any concerns in regards to the cleanliness of the CAS clinics or health centres.
- We viewed the trust's community infection control accreditation dashboard. This recorded the outcomes of community infection control audits from April 2015 to August 2015. We saw that an overall rating of 100% was achieved every month against a trust target of 98%. This demonstrated that cleaning standards were monitored to ensure they met national specifications.
- We saw that shared equipment, for example scales and blood pressure equipment, were labelled to indicate when they had been cleaned and that they were ready for use.
- We observed that clinic environments and offices we visited had adequate supplies of personal protective equipment (PPE). We observed staff using PPE appropriately in clinics. We also observed staff carrying adequate supplies of PPE, and using PPE when they visited patients at home.
- We saw that all the premises we visited had adequate hand-washing facilities and supplies of hand sanitizer for staff and the public to use. We viewed the trust's analysis of hand hygiene audits carried out across Northumberland and North Tyneside in June 2015. This recorded that of 808 of 814, 99.3% observations of community staffs' hand hygiene practice was compliant with trust's standard of 98% compliance.

Mandatory training

- Staff told us they could access their training records electronically on the trust's electronic staff record system. Staff told us they could request further training in addition to their mandatory training if it was relevant to their role.
- We reviewed the CAS records for staff training which were broken down by service. We saw that between 85% and 100% of mandatory training had been completed across CAS against a trust target of 85%.
- Mandatory training records indicated that 100%, against a trust target of 85%, of CAS nursing staff had up to date training in 'slips, trips, and falls'. This was training in preventative measures that could be taken to keep staff and people who use services safe in both clinics and the home environment. However, the mandatory training record indicated that only 50% of CAS nursing staff had up to date training in 'moving and handling.' This meant

that 50% of CAS nursing staff needed to update their mandatory 'moving and handling' training to minimise the risk to staff and people who use services when being moved or transferred. We noted that the trust's mandatory training record indicated that 100% of CAS nursing staff and cardiac rehabilitation staff, against a trust target of 85%, had completed training on medical devices.

- Managers told us staff were supported to attend mandatory training within their working hours. Mandatory training for CAS included fire safety; health and safety; information governance; infection control; moving and handling and safeguarding.
- Staff we spoke with told us they were supported to attend their mandatory training by their managers and that they received reminders when it was due.

Assessing and responding to patient risk

- Community based staff we spoke with were able to demonstrate awareness of the key risks to patients, for example, risks of falls and pressure damage. We viewed eleven patient records during home visits. As part of our review of patient records, we found that risk assessments were fully completed for each patient. These included skin integrity, nutrition, pain assessments, falls risks, and activities of daily living.
- The risk of patients acquiring pressure ulcers was identified as a primary concern for community patients. Pressure ulcers assessed as a severity of grade three or above were referred for investigation as a serious incident and a RCA was undertaken. The tissue viability service (TVS) had produced a new wound management formulary and guidance for staff on managing people's skin. This had resulted in the Trust moving from being worse than the England average in regards to pressure ulcer care to better than the England average.
- Staff told us that having access to SystmOne and SWIFT electronic record systems, as well as mobile working, had improved patient access and reduced the amount of paperwork district nurses had to complete. Referrals from G.P's and hospitals were immediately logged onto SystmOne. Patients who were at risk of deteriorating were identified on SystmOne, as well as at district nurse hand-overs to out of hours district nursing services.
- The STSS service demonstrated how the SystmOne record system carried alerts for staff to identify patients who were at risk of deteriorating. GP's could refer patients directly to the STSS service if they thought a patient would benefit from extra support.
- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather. CAS had a winter plan in place. This included community staff having access to 4x4 cars to maintain staff safety and to support access to patients in all community settings. The plan also provided telephone access to specialist services, which would provide advice to patients and staff during adverse weather. Planning included using staff that may be snowbound to visit patients in the area where they lived, and who were within walking distance. Winter plans were drawn up in collaboration with emergency services including the fire brigade and police.
- Referrals from G.P's and hospitals were immediately logged onto SystmOne, which identified patients who were at risk of deteriorating. The H2H service demonstrated how the patients' record system carried alerts for staff to identify patients who were high risk.

Staffing levels and caseload

- We looked at staffing rotas for the month of November 2015. We saw they were constructed to ensure there were appropriate numbers of staff at appropriate grades on duty to carry on the service. We saw rotas had been amended in the light of unforeseen absences to ensure that the service could continue to operate safely.
- All district nursing teams were skill mixed, comprising of one Band 6 and a number of Band 5s, based on the practice population size and geography. Teams also had access to Band 3 time, which might be shared between two teams. Information on the skill mix and district nurses' caseloads was routinely collected and reviewed by operational managers. Caseloads were managed via SystmOne patient records. The care plan and visit schedule provided details of acuity and the number of home visits that needed to be allocated.
- Locality leads and operational managers assessed the level and acuity of caseloads, and allocated staff resources to meet the needs of all teams. Community matron's completed a 'caseload analysis' form to assess their activity. These were monitored by operational

leads. Workload and the complexity of the caseload were discussed and where necessary staff, or patient visits were reallocated to ensure patients' needs would be met.

- Northumberland and North Tyneside had a combined district nursing staffing level of 401.34 was the established whole time equivalent (WTE) figure for district nurses. This was the number of staff the Trust has assessed the service as requiring to provide services based on the needs of the population being served.
- The Trust's WTE spreadsheet recorded that in September 2015 there were 393.08 WTE district nurses working across Northumberland and North Tyneside. This meant the Trust had 8.26 WTE unfilled district nursing posts. There were 1.41 Bank district nurses being used against and established figure of 0.8. Staff confirmed that flexible staffing and reallocating resources was an option that was used to maintain safe district nursing caseloads.
- When we spoke with staff they all reported that recruitment and retention was good, with the exception of physiotherapy staff. Physiotherapy staff told us there was a lack of promotion opportunities with the Trust and this had led some staff to consider moving to other Trust's for promotion opportunities. Physiotherapy support was offered seven days a week, with staff working a one in six weekends rota. However, some staff told us they were unhappy with the current system as some Band 5 physiotherapy staff were on a six month rota, this meant working regularly at weekends in a six month period.
- The CAS risk register highlights a risk of a gap in services at NSECH; during the preparation for NSECH the CBU was given an opportunity and encouraged to submit plans in terms of impact on OT, SLT and H2H services. This was a new hospital which had recently opened. Additional posts were presented in business cases to support NSECH working. Services affected included occupational therapy (OT), speech and language therapy (SALT) and Hospital to Home (H2H). The register identified a lack of weekend cover resulting in delayed hospital discharges and a risk of local sites cover, due to staff and services being reallocated to NSECH. An action plan was produced highlighting the extra staff required. Business cases were prepared and presented by the OT lead and head of therapies. Extra funding was agreed in March 2015 as part of NSECH steering group actions and some investment was released to support H2H and OT services to cover NSECH. Service provision was being remodelled to accommodate NSECH in terms of staffing, and there work was in progress to review and assess service risks in regards to the impact of NSECH on local base sites.
- Some staff in the DN teams told us they did not routinely record staffing shortages on the electronic incident reporting system. It is important that staffing shortages are recorded as incidents to enable the trust to monitor safe staffing levels and ensure staffing shortages do not pose a risk to patient care.

Managing anticipated risks

- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather. Staff told us that SystmOne identified vulnerable patients and calls would be allocated on the basis of care and complexity, this ensured the needs of vulnerable and highly dependent patients were met during the winter and during heatwaves.
- The service had a winter plan in place. This included community staff having access to 4x4 cars to maintain staff safety and to support access to patients in all community settings; the plan also provided telephone access to specialist services, which would provide advice to patients and staff during adverse weather. Planning included using staff that may be snowbound to visit patients in the area where they lived who were within walking distance.
- The trust had comprehensive 'Emergency Preparedness, Resilience and Response Policies and Plans' including winter pressures.
- The CAS maintained a risk register that identified current risks and rated the level of that risk. Key control measures were put in place and we saw that action plans were in place to mitigate and manage the risks identified. We were able to test the control measures for the risk relating to syringe drivers and found that these were all in place.

Outstanding ☆

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 rated effective as outstanding because:

We found Community Adult Services (CAS) achieved an outstanding standard of effectiveness. Overall, we saw that national guidance, the National Institute of Health and Care Excellence (NICE) and professional bodies were complied with and that staff showed awareness of relevant guidance in their work. Staff were actively engaged in activities to monitor and improve quality and outcomes. For example, the tissue viability service (TVS) used the SSKIN bundle, this was a five step model to reduce incidents of pressure ulcers and endorsed by NHS England. The service had gone further in pioneering their own pressure ulcer and skin integrity 'aide memoire' for staff to assist in identifying patients at risk of developing pressure ulcers. This had resulted in the trust moving from being a national outlier for pressure ulcer care to consistently performing better than the national average.

We found that overall quality of care was monitored through audits, which informed the development of local guidance and practice. We found that patients could access all professionals relevant to their care through a system of truly integrated multi-disciplinary teams; and that patients' care was co-ordinated and managed. There were systems to gain people's consent prior to care and treatment. Where patients lacked the capacity to give consent, there were arrangements to ensure that staff acted in accordance with their legal obligations.

Staff were supported through face-to-face meetings with their manager and through an annual appraisal which generated a personal development plan for each individual. Staff were encouraged and supported by the organisation to gain additional qualifications relevant to their role, and staff in senior positions held appropriate qualifications. There were robust systems to ensure professional staff remained registered with the relevant professional body.

Detailed findings

Evidence based care and treatment

- All CAS services worked to Northumbria Healthcare Trust policies and procedures, which were developed to reflect relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), government departments and professional bodies. Staff understood their individual roles and responsibilities in the delivery of evidence based care. Staff referred to relevant codes of practice. Staff used nationally recognised assessment tools to screen patients for certain risks. For example, infection control procedures. Patient's assessments were completed using templates that followed national guidelines. For example, skin integrity, falls risks, nutrition, pain management, and activities of daily living. Records we viewed were completed in a timely way and at appropriate intervals.
- The tissue viability service (TVS) used the SSKIN bundle, this was a five step model to reduce incidents of pressure ulcers and endorsed by NHS England. The service had gone further in pioneering their own pressure ulcer and skin integrity 'aide memoire' for staff to assist in identifying patients at risk of developing pressure ulcers. This had resulted in the trust moving from being a national outlier for pressure ulcer care to consistently performing better than the national average. This was confirmed when we viewed the TVS dashboard for pressure ulcer care which was benchmarked against the national average.
- Staff we spoke with understood how NICE guidance informed local guidelines. We observed staff following appropriate assessment guidelines when delivering care to patients. We saw copies of relevant documents were available at bases for staff to reference, and staff told us they could also access this via the trust's intranet site.
- Staff received the minutes of meetings where guidance was discussed; these included changes to practice which might affect their area of work. Audits were used in the service and informed the development of local guidance and practice.
- We observed the care for people at risk of falls was broadly compliant with guidance from the National Institute of Health and Care Excellence (Falls: assessment and prevention of falls in older people CG 161).

Are services effective?

- Clinical procedures undertaken by community nurses were based on best available evidence within the Royal Marsden Manual of Clinical Procedures. Community Nurses followed NICE guidelines and specific guidelines for Long Term Conditions Management, for example, COPD Gold Guidelines; and the Palliative Care Gold Standard Framework.
- Staff could access guidance and pathways for certain long-term conditions on the trust intranet. We found community nurses used national guidance in the form of patient group directions (PGD's) in the administration of prescription medicines. For example, there were PGD's for the administration of vaccinations such as: influenza, pneumonia, shingles and the administration of adrenaline.
- The CAS had a wide range of standard operating procedures (SOP's). SOP's are a step-by-step description of all the processes that take place which all staff are expected to follow; and therefore minimise any risks, errors or misunderstandings that may occur. For example, 'no reply home visits SOP'; 'CD (controlled drugs) risk assessment SOP'; 'SOP Home notes – long term patients'; 'SOP for ordering adrenaline'; and 'SOP for the use and decanting of liquid nitrogen'.
- The CAS had specialist community research nurses that were funded by the trust's research and development team. For example, the TVS research nurse was involved in a clinical trials study with a university into pressure ulcer mattresses. The TVS service had also conducted research for a large corporate company who specialised in providing products for advanced wound management.

Nutrition and hydration

- We saw examples where, on initial assessment, potential risks of malnutrition and possible dehydration were identified and actions were taken to address these concerns.
- We saw patients were assessed for risk of malnutrition using a validated, nationally recognised risk assessment, the 'malnutrition universal screening tool' (MUST) in services where this was appropriate, for example community nursing. The patients' nutrition and hydration assessments we viewed were completed appropriately. We saw that care plans were in place for nutrition and hydration and reviewed regularly.
- Where a need for additional support with nutrition and hydration was identified, for example with diabetic patients, community and specialist nursing staff referred patients to a dietician, who provided practical advice for patients about healthy food choices and to work with patients to change their eating habits.
- Extensive information leaflets and posters about nutrition and hydration were available to staff from the trust's Health Improvement Service (HIS). We viewed a trust leaflet in a patient's home, 'Healthy Eating for older people, L17B'. The patient told us they had been given information on nutrition by the district nurse. The HIS leaflets were also available on the trust's website.

Technology and telemedicine

- New evidence-based techniques and technologies were used to support the delivery of high quality care. The CAS service used a range of new technologies, such as movement sensors linked to an alarm for use at home. Staff we spoke with knew about these technologies and how to access them for patients. For example, the Short Term Support Service used telecare falls sensors to help manage patients at risk of falls; as well as carer alert monitors, that would contact a friend or relative if the patients alarm was activated. The Short Term Support Service also utilised the use of telecare medication dispensers these are units that prompt patients when to take their medicine and dispense the tablets patients are due to take. If a patient did not take the medicine the system automatically notified a carer, friend or relative. The medication dispenser unit only dispensed the tablets at the required time; hence the risk of a patient taking a repeat dose was reduced.
- We found that community nursing staff were rolling out tablet computers. Staff told us the tablet computers gave then access to reference materials when they required them, and were loaded with applications detailing current guidance. For example, staff could access the most up to date British National Formulary (BNF). District nursing staff in Alnwick told us the tablets had made a significant difference to practice in rural areas, as district nurses could access patient records in 'real time' instead of having to drive long distances to the Trust's offices to gain access to best practice information or patient records.

Patient outcomes

- We found opportunities to participate in bench marking, peer review, accreditation and research were proactively pursued by the CAS. Information about the outcomes of

people's care and treatment was routinely collected and monitored. For example, the service benchmarked patients' outcomes against the, 'adult social care outcomes framework' (ASCOF). We viewed the trust's ASCOF monitoring spreadsheet dated October 2015. The trust was doing better than the North East region and England national average in 43 of the 48 ASCOF outcomes.

- The outcomes the trust was not meeting related to the number of patients and carers who were receiving direct payments; Proportion of adults in contact with secondary mental health services who live independently, with or without support. The trust's figure was 42% in comparison to the national average of 59%; and long-term support needs of younger adults (aged 18-64) admissions to residential and nursing care homes, per 100,000 population; the trust's figure was 21% compared to the national average of 14%.
- We viewed the CAS audit planner dated November 2015. There were 48 audits planned or completed between March 2015 and January 2016. The audit planner identified what service standard the audits were being measured against. For example, an audit of hip fractures by the OT service was measured against the requirements of NICE guidance CG124 'hip fracture management'.
- The CAS has a monthly 'integrated governance meeting'. Patient outcomes performance measures as well as internal audits were a standard agenda item at the meetings. For example, the May 2015 meeting minutes recorded that the divisional managers and team leads had discussed the Community Information Data Set (CIDS). This is a patient level data set which delivers robust, comprehensive, nationally consistent and comparable person-based information on patients who are in contact with community services. The minutes recorded that the CAS performance was 79.9%, against a national target of 50%; however, the minutes recorded that CAS had set their target at 90%. This meant CAS were exceeding national CIDS targets by 29.9%; but, had set CAS targets 40% higher than the national target to monitor and improve the quality of services people received.
- The CAS used a dashboard to monitor patient outcomes. We viewed the May 2015 dashboard performance report. This reported that the CAS service was achieving trust targets in regards to safety and quality outcomes. For example, the trust target for chronic obstructive pulmonary disease (COPD) patients with and exacerbation plan was 85%. The CAS had exceeded the target in Northumberland by achieving 89% and by achieving 95% in North Tyneside.

Competent staff

- We saw records that showed 100% of staff had attended a corporate induction programme.
- We were shown records that showed competencies relevant to staff roles had been developed and there were systems to ensure competency was demonstrated and reviewed. We viewed district nursing medicines competency assessments and found these were comprehensive and up to date.
- Staff told us they had regular, formal meetings with their line manager which were recorded. We were shown examples of monthly one-to-one meeting between a staff member and their manager. We saw it covered a wide range of issues relating to the management and development of the service and team, updating on clinical and corporate issues, and discussions on personal performance and development.
- We saw there was a process to assure the organisation that its registered staff remained registered with relevant professional bodies. Staff and managers were advised when trust records indicated registration was due for renewal and re-registration was verified. A district nursing team lead demonstrated how the system worked and was monitored.
- Staff told us they were supported to gain further qualifications relevant to their role. We saw that senior community nurses held specialist qualifications, and we spoke with a number of staff who had been supported to become non-medical prescribers.
- Patients we spoke with expressed confidence in the skills and competence of those caring for and treating them. A typical comment was, "I haven't had any reason to doubt them. They have been first class."
- District and specialist nursing staff had received annual appraisal as an aspect of their continuous professional development (CPD). Community nursing teams had achieved at least 90% of staff in each team having received an annual appraisal in the previous 12 months. In the admission avoidance team and H2H teams 100% of staff had received an annual appraisal. Across community services a high level of compliance was reported overall.

Are services effective?

- A corporate induction was completed by staff joining the service. Staff told us new staff also received an induction at locality level.
- Staff training and development was supported. We found the service encouraged skills development. Staff of different grades confirmed that training needs were identified as part of appraisal, and staff could request further training that was relevant to their role. Staff were supported to continue their education. For example, senior managers told us work was in progress to develop new roles for clinicians, to provide them with alternative career progression pathways. Senior managers said clinical skills were lost due to staff being promoted in to management and the clinical skills being lost. The CAS were looking at developing new clinical roles that staff could be promoted in to, with the objective of keeping clinical skills and clinical experience in the provision of patient care.
- Staff told us individual supervision took place every four to six weeks, and there was regular supervision in team meetings.
- The team manager at the TVS had been involved in developing a competency framework for practitioners in collaboration with a university and a market leading company in wound care.

Multi-disciplinary working and coordinated care pathways

- The CAS had a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. For example, staff at the TVS were active partners in research work with UK universities and industry. The trust's former Community Rehabilitation Service was developed and became the STSS which had an agenda built on the integration of health and social care; this included the trust employing registered social workers to undertake care management functions. Hospital 2 Home was also developed to support vulnerable discharges and prevent hospital re-admissions.
- We saw examples of agreed care pathways expressed as algorithms in order to guide staff. For example we were shown the 'podiatry pathway for patients with diabetes'. We also looked at the STSS 'new falls pathway' which was structured to support effective communication between teams and services; as well as the 'passive incontinence' algorithm, this described the process for accurate continence assessment and the supply of continence aids.
- We spoke with a patient with complex needs. They were very positive about the standard of care they had received. The person told us, "I can't tell you how tremendous all these people have been. They have all worked exceptionally well together to give me my life back."
- We found that social care staff were employed by the trust and co-located with health professionals which facilitated a joint approach to providing holistic care that met the needs of patients and their families and carers. We observed interactions between these staff groups which enabled them to respond quickly to the needs of patients, especially when these were changing. We saw that social care assessments were offered by the trust's social workers.
- Specialist nursing staff provided support for community clinics and professional advice for district nursing colleagues to support multi-disciplinary working and the use of best practice for patients. Nursing staff told us they felt well supported by other professional staff that provided multi-disciplinary support.
- Specialist clinical leads worked effectively in multi-disciplinary teams. For example, the clinical lead for the specialist podiatry service maintained links with other specialists including physiotherapists and occupational therapists.
- For district nursing, multi-disciplinary team meetings could be convened to address the needs of patients with complex care needs.
- The TVS had developed an order form for nursing homes to order wound care products to avoid nursing homes ordering too many products that wouldn't be used and would pass their use by dates. Staff told us the order form had been received positively by both the nursing homes and G.P's.
- The TVS had arranged a 'stop pressure ulcer day' regional training day for trust's from across the north of England in November 2015.
- CAS ran a free of charge 'Inspired Carer Masterclass' for staff from local residential care and nursing homes to improve care for patients receiving care in care homes. This was a one day course for care home managers and staff. The training covered dementia care, falls

prevention, infection prevention and control, swallowing assessment, depression, skin integrity, and supporting families. The training was delivered by a variety of CAS staff including community matrons, SALT, and physiotherapists.

- The podiatry service showed us a pain tool they used to assess a patients level of pain. Staff told us people were asked if they were experiencing any pain at every appointment and people who reported any pain would receive a pain assessment. We did not view any completed patient pain assessments. However, we viewed the podiatry pain assessment tools and staff explained how these would be used in practice.

Referral, transfer, discharge and transition

- Referrals for in hours community nursing in North Tyneside were made via the Single Point of Access (SPA), 8.30am to 5pm Monday to Friday. The SPA team worked to SOP's to ensure patients were referred to the appropriate services, in the correct timescale. The call centre at Foundry House provided a single telephone number for referrals to community services and a single information point for social care. This is with the aim of making it easier for people to know where to call in order to get the right help and information they need. Services responded quickly and waiting times were low in the service areas we visited.
- Referrals in hours in Northumberland went directly to the team, who triaged and either arranged a visit, or referred on to the most appropriate service. The trust was recruiting to increase the call handling capacity of the SPA, to route Northumberland DN referrals through the SPA.
- For both Northumberland and North Tyneside services out of hours all calls were routed through the MDT SPA based in Foundry House.
- We viewed the CAS 'mystery shopping exercise report for adult social care,' dated November 2015. The aim of this mystery shopping exercise was to measure the service provided to patients at the first point of contact when making an enquiry in relation to social care and health services, and the information or support available to them. The exercise found that the average queuing time before speaking to a SPA call handler was two minutes.
- The STSS facilitated hospital discharges and provided same day care or therapy support to patients who had been discharged. Access to the service was via the SPA. All referrals to the STSS were monitored every 15 minutes. Urgent referrals for immediate response were allocated through an actual or virtual MDT process to determine the level of action required and the appropriate management of risk. The service provided five days a week daily duty system with guaranteed same day response from both care and therapies. Care plans could be negotiated at weekends to support weekend hospital discharges with the approval of the STSS on call manager.
- H2H was a service set up to avoid admissions where possible by triaging patients in the hospital emergency department or patients who had been admitted to hospital.
- The Community Nursing Service had an urgent two hour response time for patients on the caseload, for example, patients receiving palliative care or with blocked catheters. CAS told us that if an urgent task was received, the team taking the referral would contact the patient to establish the nature and urgency of the call and to provide interim advice. Non-urgent calls would be offered an appointment for a visit for a specific day based on treatment required.
- Patients could access community services promptly. For example, the CAS were meeting 100% of referral to treatment times for: podiatry; dietetics; occupational therapy; and SALT.
- CAS had referral pathways and procedures in place. Referrals to community services were from a variety of services including GP's, practice nurses, district nurses, patients being discharged from hospital, complex cases in nursing and residential care homes, and others including the police. Staff told us there were clear criteria for referral of patients which meant that inappropriate referrals could be identified.
- The STSS team facilitated hospital discharges, reduced long-term care and provided out of hours nursing services. Therapists in the team provided goal-orientated, time limited interventions, aimed at improving patients functioning and independence. Nurses in the team could arrange domiciliary services to prevent avoidable admissions to hospital; and could ensure access to community nurses 24 hours a day. Staff from the STSS team told us they worked closely with the discharge nursing team at North Tyneside general hospital and NSECH.
- Discharge arrangements from hospital were supported by community teams. For example, the cardiology

specialist nurse attended multi-disciplinary team meetings at the acute hospital with cardiology consultants and liaised closely with community nursing teams about discharge arrangements.

- Patients were discharged from the community nursing caseload if they were admitted to hospital. Community nurses liaised with the hospital ward to support patients' admission. If a patient was due to be discharged to their home, the acute hospital would refer to the SPA. The hospital readmission rate within 30 days of being discharged was 6.3%.
- We viewed the community cardiology referral pathway flowchart. This outlined the patients' journey through the community cardiology service. We observed patients attending a community cardiology clinic. The service did not accept self-referral; patients using the community cardiology service were referred by a health care professional. We saw patients receiving full physical examinations. During the observation we saw community cardiology staff explaining treatments to patients in accessible language, as well as agreeing future care and treatment plans with patients. The service had achieved 100% patient satisfaction in the NHS Safety Thermometer survey between July – September 2015.
- Patients and carers we spoke with told us that they did not experience difficulty getting care and treatment when they needed it. One patient told us, "They come as quickly as possible when I phone." Another said, "They don't keep you waiting for ages."
- Staff told us the CAS service had run a trial on offering extended hours clinics on Saturdays to enable people with work or other commitments to attend when it was convenient for them. However, this had not been implemented due to a lack of demand, and patients saying they did not want to attend clinics at weekends.
- Patients we spoke with told us that clinics ran on time and services visited when they expected. A patient said, "They are pretty good at being on time, and 'they will phone if they are going to be late."
- Staff we spoke with told us that visits were rarely cancelled as they were able to pass on any uncompleted work to the evening or out-of-hours teams. Patients did not tell us that missed or late calls were a frequent occurrence.

Access to information

- Staff at the STSS service and district nurses demonstrated how they could access all the information needed to deliver effective care and treatment in a timely and accessible way. For example, we viewed patient's paper based notes in their homes and saw these included care plans and risk assessments. District nursing staff also demonstrated the use of SystmOne to gain access to case notes and patients test results.
- Social workers at the STSS team demonstrated how they had access to both the local authority SWIFT electronic records system and SystmOne. Staff explained that STSS team having access to both systems made it easier for staff working with the patient to access relevant information from referral, discharge, transfer and transition, in a timely way and in line with relevant protocols.
- District nursing staff told us mobile working had increased their ability to deliver effective care and treatment by improving access to patient records whilst working in the community.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of their responsibilities in relation to the Mental Capacity Act 2005 and could describe how they applied it in their daily work.
- We saw examples of records of best interest meetings that had been held when patients lacked capacity to make a decision for themselves. Overall, they complied with the Mental Capacity Act 2005, Code of Practice 2007.
- We found there were procedures in place for patients who lacked capacity to have access to an Independent Mental Capacity Advocate (IMCA) when serious decisions about their health and welfare needed to be made in their best interests. We were did not see evidence of the referral rates or patterns of CAS overall performance in regards to IMCA referrals.
- We found patient consent forms had been signed by the patient or their relative and representative. We also observed staff gaining verbal consent before providing care.
- We viewed the trust's Mental Capacity Act 2005 training record. We found 100% of staff against a trust target of 85% had completed training in the Mental Capacity Act 2005.

Outstanding ☆

Are services effective?

- A TVS research nurse told us that all research nurses were trained in informed consent for patients who wished to participate in research. The trust had a policy in place for gaining consent from patients who had agreed to be involved in research.
- We attended seven home visits with DN's and observed staff asking patients for their consent prior to providing care or treatment.

Outstanding ☆

Are services caring?

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

Summary

We rated caring as outstanding because:

We found that Community Adult Services showed outstanding standards of caring. This was because patients and carers we spoke with were overwhelmingly positive about their experience of care and treatment, and feedback gathered by the organisation showed high levels of satisfaction. Words and phrases such as "tremendous," "cheerful and considerate," "extremely happy with the care," were used extensively in their feedback. We viewed the Community Services Business Unit (CSBU) Friends and Family Test (FFT) results November 2015; 99% of patients said they were treated with dignity and respect. We reviewed results from the FFT for the period July – September 2015 for 24 Community Adult Services Teams. The average score for people who responded that they would be likely to recommend community services was 99%.

We observed all staff responding to people with kindness and compassion. Patients told us they were treated with dignity and respect, and that they were involved in the planning and delivery of their care to the extent they wished to be. Staff were prepared to and did go the 'extra mile' for patients. For example, a district nurse told us they had on occasion collected firewood for an older patient in a rural area to ensure they had fuel for a fire.

Detailed findings

Compassionate care

- Patients and carers we spoke with were overwhelmingly positive about the care and treatment they received from Community Adult Services. Words and phrases such as "tremendous," "cheerful and considerate," "extremely happy with the care," were used extensively in their feedback.
- We viewed the Community Services Business Unit (CSBU) Friends and Family Test (FFT) results dated November 2015, 99% of patients said they were treated with dignity and respect. We reviewed results from the FFT for the period July – September 2015 for 24 Community Adult Services Teams. The average score for people who responded that they would be likely to recommend community services was 99%.
- The October 2015 'Integrated Governance and Performance' meeting report carried the results from the 'Two minutes of your time' patient survey. The survey demonstrated that 3492 community services patients responded to the survey in the previous three months and 99% of patients responded that they were treated with dignity and respect. A patient comment included, "Rapid response carers carried out my relatives care with the greatest respect, kindness compassion and skill. I cannot praise them enough."
- We accompanied staff on seven home visits and observed that staff were respectful of patients' homes, and that matters of dignity were given due consideration.
- We observed an OT providing a follow up appointment with a patient. We saw the OT displaying rapport with the patient and responding to the patient with kindness and compassion.
- A district nurse lead in Alnwick had been involved in arranging a public welfare funeral for a patient who died and lacked funds. The district nurse had also attended the funeral service for this person.
- District nursing staff at Alnwick told us they had been asked by their team lead to provide social assistance to people in rural areas due to the risks posed by social isolation. A district nurse told us they had on occasion collected fire wood for an older patient in a rural area to ensure they had fuel for a fire.

Understanding and involvement of patients and those close to them

- In the Community Services Business Unit (CSBU) Friends and Family Test (FFT) results for July - September 2015, 97% of patients said they received the information they needed. We reviewed results from the FFT for 24 Community Adult Services Teams. The average score for people who responded that they would be likely to recommend the service was 99% with a range of 50%-100%.

Outstanding ☆

Are services caring?

- In the 'Two minutes of your time survey' 97% of patients reported that the treating professional provided them with all the necessary information about their condition or illness.
- We attended seven home visits and saw staff demonstrating good communication skills during the examination of patients. Staff gave clear explanations and checked patients understanding.
- We saw district nurses taking time to clarify patients understanding of their care and treatment; carers we spoke with told us they were reassured by the nurses' knowledge and advice.
- Specialist nursing staff provided an educational resource for patients and carers. For example, staff at the community cardiology nursing team provided care to patients with disorders of the heart and blood vessels. Staff we spoke with told us they also provided patients, families and carers with education about heart disorders; as well as advice and support.
- The service's TV team provided support with skin care. TV specialist nurses provided telephone support for community teams and facilitated training days. The tissue viability team provided information on the prevention of pressure ulcers to staff and patients.
- There was a large amount of printed information available to patients across CAS. Patients could also access the CAS information leaflets on the trust's website.
- In our discussions with staff, patients and carers we found that there was an appropriate rehabilitation focus and that patients were encouraged to be partners in their care planning and enabled to participate in care activities.

Emotional support

- In the 'Two minute of your time' survey dated July – September 2015, 97% of patients felt supported during their appointment or visit.
- We observed staff providing emotional support to patients and to relatives. Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for patients where this was needed.
- During home visits we observed staff responding to people in a kind and compassionate manner. All the patients and carers we spoke with were positive about the emotional support the community staff provided.
- Staff and patients told us about the emotional support staff had provided for patients and carers. For example, a patient told us how staff had supported them emotionally through their recovery from a stroke. The patient told us, "These people helped me to see that I had a future; and day by day I get a little bit better. They have given me my life back. I think they are tremendous."

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

The involvement of other organisations and the local community was integral to how services were planned and ensured that services meet people's needs. We found that community adult services had a model of integrated community teams across health and social care to ensure people received truly joined up working that was responsive to patients' individual needs. There was a focus of providing services close to where people lived and at times that were convenient to them. There was provision to ensure that essential services were available out-of-hours, and there were no major issues with waiting lists.

The initial response team (IRT) had a skill mix of nursing staff, occupational therapists, social workers, reablement and social care staff to ensure appropriate assessments. The IRT team attended daily multi-disciplinary team meetings to plan proactively, reducing the length of any unnecessary stays in hospital and providing innovative solutions to obstacles. For example, a patient that was medically fit for discharge but due to a fracture wasn't able to transfer independently found that the care home didn't have a wheelchair for the patient to use on discharge. The care home stated they could not take the patient back as they did not have a safe method of transfer. IRT delivered a wheelchair immediately, and the patient returned home that day.

The local authority home improvement service was integrated with community OT services, enabling swift responses for adaptations and minor works.

The Hospital 2 Home (H2H) team worked with Age Concern volunteers to enable swift discharge for patients who required low level support, for example shopping or dog walking.

Community Nurses case managed social care patients with complex life limiting health or social care needs. This gave them direct access to brokers who could amend care packages. The service was developed in response to unnecessarily long delays for changes in care packages for vulnerable patients with complex needs, and to avoid unnecessary admissions to hospital.

Community Matrons for mental health and wellbeing worked in partnership with primary care to ensure 'hard to reach' patients. A plan of care was devised in partnership with the patient, which was tailored to the individual patient's needs.

STSS worked in partnership with Age UK to provide a community falls exercise programme as part of the community falls pathway. The STSS service had a decision making forum that met daily. All referrals were processed based on client need and signposted to the appropriate services. Referrals received outside of the forum were monitored every 15 minutes. Urgent referrals were scrutinised via a virtual MDT to maintain multi professional decision making. Urgent referrals could be responded to within an hour.

Speech and Language Therapy staff worked with nursing homes to support nursing home staff with the care of people with dysphagia. This led to the development of resource packs for the homes, which consisted of screening tools, checklists, advice sheets and on-site training delivery.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met needs and promoted equality. This included people who are in vulnerable circumstances or who had complex needs and patients for whom English was not their first language. Feedback from patients was actively sought and acted on. Complaints were investigated and responded to, staff were made aware of the issues raised by complaints and where appropriate changes were made as a result.

Detailed findings

Planning and delivering services which meet people's needs

- Community services had a model of integrated community teams across health and social care to ensure people received truly joined up working. The aim of the service model was to improve patient outcomes and experience through bringing existing community services from health and social care into a more combined way of working. The aim of the model was to

reduce the number of different professionals that patients needed to interact with, and reduce duplication of work, with an increased focus on personalised care and self-care.

- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- We found service specifications were in place for most services which included the aims and objectives of the service, as well as the expected outcomes for patients. Staff we spoke with told us they had developed good working relationships with commissioners, other providers and stakeholders to ensure multi-disciplinary working and continuity of patient care. For example, patients requiring urgent care were referred to the STSS service, where they were assigned a key worker who would discuss what help patients needed and developed care plans in partnership with patients and their families. The service was available for up to six weeks.
- Senior managers told us the trust worked very closely with both the Northumberland Clinical Commissioning Group (CCG) and held regular meetings with the local authority to review population data, disease prevalence and service modelling to reflect the local needs identified in the Joint Service Needs Assessment (JSNA); this is an assessment that pulls together information about local health and care and support, and is a vital tool to help plan future services.
- We saw tracking records demonstrated that patients assessed as high risk of pressure damage, or who had such damage, were provided with appropriate pressure relieving mattresses to meet their needs. These records also showed that hospital style beds were supplied to patients when their care needs and condition warranted this.
- We saw services were provided in well maintained premises. There was full disabled access with lifts, ramps and disabled toilet facilities all present. Signage in health centres and clinics was clear and directed patients to appropriate areas.
- Premises contained adequate waiting facilities with comfortable chairs and patients had access to drinks and other refreshments.
- We saw there were extensive displays and leaflets covering condition-specific topics, general health advice and signposting to local health and social care services.

Equality and diversity

- Staff we spoke with were aware of the need to obtain interpreting services when required and could describe the process for doing so. This meant that patients whose command of English was insufficient to ensure they could communicate their needs, symptoms and experience were supported.
- We did not view the percentage of staff that had completed equality and diversity training as this was not included on the CAS staff training record. However, the staff survey 2015 recorded that 64% of staff reported having received equality and diversity against a trust average in the staff survey of 66% reporting having received the training.
- Staff told us all of the trust's printed information was available upon request in any language from the trust's accessible communications team.

Meeting the needs of people in vulnerable circumstances

- We saw patients with dementia were identified to staff through the use of the national 'Butterfly scheme'. This involved a discreet butterfly symbol so that staff would be aware of their special needs. We saw these symbols in use on patients' notes. Staff we spoke with were aware of the significance of the butterfly symbols and could discuss with us how they might approach communicating and managing the care of people living with dementia and their carers.
- We did not visit the Trust's learning disabilities team during our inspection. The community learning disabilities team provided a range of services for people with a learning disability. Services were provided by nurses, social workers and other professionals who worked with patients both in the home and in primary care settings such as clinics and GP surgeries. We saw a range of leaflets had been produced in easy read format by the learning disabilities team and were readily available across the trust's locations.
- We saw information was available in locations we visited on the trust's 'dementia advisor' scheme. Dementia advisors were staff trained in supporting and advising patients living with dementia and their carers.

Good

Are services responsive to people's needs?

Access to the right care at the right time

- The CAS informed us that patients did not routinely wait to be treated by the community nursing service. The service responded when the patient needed to be seen. Community nursing services were available 24/7. This meant patients could access care at any time, and they, or other health and social care professional could contact the community nursing service at any time if required.
- District nurse home visits would normally take place between 8am and 7pm Monday to Friday. Staff told us patient needs would determine what time they were visited, for example if a patient needed an injection at a certain time. Patients who needed a visit outside of DN hours were visited by the DN out-of-hours team.
- Community matrons had a target time of 72 hours for new referrals. Community matrons told us they were achieving 100% of their target times for new referrals.
- CAS informed us that community nursing services had an urgent 2 hour response time for patients who were in receipt of palliative care or who had a blocked catheter. If an urgent task was received the team would contact the patient to establish the nature and urgency of the call and to provide interim advice. For non-urgent calls these would be booked visits for a specific day based on the treatment required. For new referrals, if a timescale was not indicated on the referral, then the patient would be contacted to establish when a visit was required. We asked the CAS for comparative data in regards to other local trust's in regards to monitoring community nurses response to treatment times and were informed the trust do not currently collect data on this.
- Physiotherapy offered a seven day a week service. However, care as an outpatient was provided at a hospital, clinic or GP practice near patients' homes. Appointments were available between 8:30am-4:30pm Monday to Friday. However, the service also offered evening and early morning appointments on different days of the week across different locations.
- The continence service provided assessment for patients with bladder or bowel problems, as well as a home delivery service which provided continence products direct to patients homes. We viewed the continence service triage and referral to treatment spreadsheet. The service was achieving 100% of their two day triage targets and 100% of their target for patients being seen at a clinic within eight weeks of referral.
- The immediate response team (IRT) provided immediate support to enable people with a sudden illness, medical condition or change in circumstance who were at risk of hospital admission, to remain at home. Typically the team's involvement lasted for a maximum of 72 hours, if longer term care was needed a key worker was identified to discuss with patients their needs and co-ordinate any care and support.
- Patients we spoke with told us that clinics ran on time, or that services visited when they expected. A DN patient we visited in their home said, "They come on time, and phone if they've been delayed."
- Staff we spoke with told us visits were rarely cancelled as they were able to pass on any uncompleted work to the evening or out-of-hours teams. Patients did not tell us missed or late calls were a frequent occurrence.

Learning from complaints and concerns

- Information regarding the Patient Advice and Liaison Service (PALS) and how to contact them was displayed in prominent areas in all the clinics and health centres we visited. Patients also had access to information on accessing an independent complaints advocacy service in all the health centres we visited.
- We viewed the CAS complaints spreadsheet provided by the trust. We saw there had been a total of 42 complaints in the previous 12 months. We saw the main category of complaint was staff attitude, with CAS having received 12 complaints in regards to this.
- Where a complaint had been upheld patients had been offered an apology and this was recorded. The spreadsheet also recorded that the CAS were open and transparent in dealing with complaints and patients had the outcomes of complaints investigations explained to them.
- Actions taken in response to a complaint were also recorded on the spreadsheet. For example, in response to a complaint from a patient new signage had been displayed in a clinical area.
- Staff told us learning from complaints was disseminated in team meetings. When information from the outcome of complaints had been disseminated to staff this had been recorded on the complaints spreadsheet.

Good

Are services responsive to people's needs?

- The community cardiology service had changed its rehabilitation programme to reflect the needs of younger people who had raised concerns that the programme didn't challenge them sufficiently. The service had added exercises for patients with higher levels of physical fitness in response to patients concerns.

Outstanding ☆

Are services well-led?

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

Summary

We rated well led as outstanding because:

There was a clear vision and values that were shared by staff and demonstrated in their work. There was a clear articulation of the strategic direction for the service and staff felt engaged with the strategy. Consideration was given to ensure that developments were sustainable. We found evidence of innovative practice and research including partnership working with industry. The leadership drove continuous improvement and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care.

There were systems to ensure good governance and monitoring of standards and performance. There was an effective escalation and cascading of information from the board to front-line workers, and vice-versa. The service was able to demonstrate excellent patient outcomes and innovative approaches to patient care.

We found that there was a positive culture, with staff and managers feeling proud of their work and achievements and speaking well of their colleagues and the organisation. Front-line staff felt supported by their managers to deliver high quality care, and empowered to implement and participate in quality improvement projects. Managers, including those at executive level, were described as being visible, open and accessible.

Detailed findings

Service vision and strategy

- The trust had developed a vision and a set of values; "building a caring future," where quality and safety were the top priority. The community services business unit's (CSBU) vision was, "to be the leader in providing high quality, caring, safe health and care services."
- We viewed the trust's five year plan. This was a robust, realistic strategy for achieving the trust's priorities and delivering good quality care. The strategy identified the key themes of quality, safety and caring. The CSBU produced an annual plan which clearly mapped how CAS would achieve the trust's strategy. The CSBU annual plan contained an action plan using the 'specific, measurable, achievable, results, and timing (SMART)' model to monitor the CAS performance. The action plan also detailed how objectives in the SMART action plan would be financed. We noted it contained a concise, but clear vision for integrated care in the locality, as well as an overview of the essential elements of the integration and a description of the operational arrangements to enable the vision to be realised.
- There were robust systems to monitor and review the CBU's strategic progress via monthly Business Unit meetings and CAS reporting to the Integrated Governance and Performance Committee. This demonstrated that there was consensus on the organisation priorities and an appreciation of how these needed to be implemented at each level of the organisation.
- Staff were aware of and able to articulate the trust's vision. Staff we spoke with were also aware of the CAS strategic plans and the direction of the integration agenda. Staff we spoke with told us they felt engaged with service developments.
- Therapy services including SALT and physiotherapy had their own strategy which was aligned to the CSBU strategy. This included promoting a culture of research and development and ensuring there was a robust system of both clinical and corporate governance.

Governance, risk management and quality measurement

- We found there was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff. We spoke with a wide range of staff that were familiar with the service's governance structures and felt confident regarding its effectiveness.
- We reviewed the minutes of various governance meetings and found they contained information on incidents, complaints and other critical incidents, the outcome of audit activity and progress against action plans and the review of risk registers. For example, there were: monthly clinical business meetings; the quality

and safety committee met monthly; and a monthly assurance committee meeting. Minutes from all the meetings were reviewed and shared at the monthly integrated governance and performance meetings to ensure information was shared across community services.

- Staff had access to flowcharts that outlined the CSBU internal assurance reporting structure. This included strategy steering groups, governance groups, and the research and development committee.
- Community services had a risk register in place, there were systems for formally signing off action plans or removing risks from the register which ensured that matters were managed appropriately to their conclusion. The risk register was regularly reviewed and updated. The service risk register is monitored through the Trust's Assurance Committee. We viewed the risk register and noted that CAS did not have any risks rated as "high" risk. The community health risk register dated November 2015 had a total of 37 risks. 16 risks were rated as "moderate" and 20 were "low" risk. There was one risk on the register rated as high; but this related to another community service and was not relevant to CAS.
- At a local level there were daily meetings where all relevant safety information was shared with the teams. These were supplemented by weekly and monthly team meetings and we reviewed the formal notes kept of these. Staff told us they found team meetings were a means of keeping up-to-date with local and organisational matters. Staff were positive about team meeting and valued them as a source of valuable feedback and the opportunity to discuss and escalate issues.
- There were systems for gathering patient feedback and we saw the results of surveys, for example the 'Two minutes of your time' surveys.

Leadership of this service

- This service was part of the community and social care business unit which was led by an executive director, medical director and service director. There was a range of senior leaders who took responsibility for governance and risk, clinical leadership, district nursing, rehabilitation, occupational therapy and care management.
- Managers and team leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was effective and staff said their direct line managers were supportive. The senior management team for community services provided visible leadership to staff.
- Staff in specialist nursing teams felt their line managers were supportive and accessible. Although they did not often encounter senior management, they felt they knew how to access them if required.
- Most Band 5 and Band 6 staff we spoke with told us they felt comfortable in their role and well supported in their development.
- The manager of the TVS had been published and presented papers to international conferences.
- The chief executive was well established in their role and known to staff in community services. Staff felt there was clear leadership at executive level. Staff told us the chief executive was approachable. Managers told us they had attended staff briefings with the chief executive.

Culture within this service

- Generally staff spoke positively of the organisation, their teams and their work. Staff reported that morale was high across CAS.
- Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. Staff told us they were able to put forward ideas and discuss them as a team.
- All the staff we spoke with were positive about integrated services and felt positive about their role and contribution in this.
- Staff said the trust was good to work for, with an open and patient focused culture. Staff said they were consulted and felt involved in decision making processes.
- Staff generally reported a positive culture in community services, although we encountered exceptions in one location, where staff felt unhappy about weekend rotas for physiotherapy staff.

Public engagement

- We saw that feedback from people who use services, the public was regularly reviewed at Integrated Governance and Performance meetings and used to inform improvements and learning.

Are services well-led?

- We viewed the trust's 'Two minutes of your time' reports for 2015-16 for community services. We found that CAS regularly achieved 100% for patient satisfaction. For example, the report dated August 2015 recorded that community nursing achieved a 100% score for patients recommending the service in July 2015. SALT also achieved a 100% score and the podiatry service achieved a score of 94%.
- The trust had a registered charity, 'Bright', the charity engaged with the local community to show art by local artists, patients, schools and colleges.
- Community locations had information on how patients or visitors to clinics and health centres could become involved with the trust as a hospital volunteer. We also saw information in health centres on how patients could join the trust and become a member, this would involve an application. Membership would convey voting rights for governors for any applicant who was approved, as well as the opportunity to stand as a governor.

Staff engagement

- We saw that teams held regular team meetings and we reviewed the minutes of these. This meant there were opportunities for staff to meet formally to discuss issues pertinent to the operation and development of their service.
- Senior managers we spoke with told us staff had a Quality Council that had completed work on staff wellbeing.
- The Community Services Business Unit had a Transformation Group which examined the development of work programmes with staff.
- We viewed the results from the 2015 staff survey. The CSBU had produced an action plan and presentation in response to issues identified in the staff survey. Issues included: The visibility of senior managers. As a result senior managers were attending team meetings and holding a question and answer roadshow for staff: Communication, the monthly emailed trust bulletin/ team brief was going to carry more information on the CSBU: Clearer guidance on annual appraisals for staff and managers: and managers feeding back to CSBU when they have acted on feedback from staff.

Innovation, improvement and sustainability

- In January 2015, the NHS invited individual organizations and partnerships to apply to become 'Vanguard' sites for the new care models programme, one of the first steps towards delivering the 'Five Year Forward View', which supported improvement and integration of services.
- Northumbria Healthcare NHS Foundation trust was appointed as one of nine 'integrated primary and acute care system vanguards', with the intention of joining up GP, hospital, community and mental health services. This was being supported through: the opening of the Northumbria Specialist Emergency Care Hospital (NSECH); an extension of primary care to create 'hubs' of primary care provision across the county seven days a week; and the redesign of community and acute services to ensure patient care was increasingly delivered in community settings, and bring together commissioning responsibility across the whole health economy. The model cut across organizational boundaries and included enhanced access to community nursing services, fully coordinated discharge and shared IT that supported better care in a number of health settings as well as patients' homes.
- The immediate response team (IRT) provided urgent support for people in a time of crisis. The IRT team joint worked across adult social care between the trust and the local authority. The partnership working had developed a range of integrated services to support care closer to home for patients and avoid unnecessary hospital admissions. The fully integrated team of community health and social care staff aimed to make contact with patients within two hours of the first call for assistance, and could provide equipment to help people move around their house, arrange emergency short term care support to enable them to remain at home, and help people to regain their confidence and independence.
- The trust employed social workers who were trained to use both the trust's electronic records system, SystmOne, and the local authority SWIFT electronic records system. This resulted in increased joined up working to meet patients' health and social care needs.
- The CAS had specialist community research nurses that were funded by the trust's research and development team. For example, the TVS research nurse was involved in a clinical trials study with a university into pressure ulcer mattresses. The TVS service had also conducted research for a large corporate company that specialised in providing products for advanced wound management.