

# The Newcastle-upon-Tyne Hospitals NHS Foundation Trust

RTD

# Community health services for adults

## Quality Report

The Newcastle-upon-Tyne Hospitals NHS  
Foundation Trust  
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Date of inspection visit: 19th January 2016  
Date of publication: 06/06/2016

# 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)
RTD	Allendale Road		
RTD	Arthurs Hill Clinic		
RTD	Armstrong Clinic		
RTD03	Campus for Ageing & Vitality		
RTD	Denton Park Health Centre		
RTD	Geoffrey Rhodes Centre		
RTD	Kenton Centre		
RTD	Lemington Walk-in Centre		
RTD	Molineux Street Walk-in Centre		
RTD	New Croft House		
RTD02	Royal Victoria Infirmary		
RTD	Westgate Walk-in Centre		

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

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

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

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

Overall, we rated this service as good because:

- Staff knew how to report incidents and most received feedback when requested. Lessons learnt from incidents were found to be shared by distribution of team meeting minutes. Pressure ulcers were the most commonly reported incident.
- We found that staff had a good understanding of safeguarding and how to report concerns.
- Medicines were managed appropriately and equipment was checked and serviced. Waste management and disposal information and guidance was in place.
- Records viewed were accurate and complete. There was some duplication of work in community services due to paper records being used alongside the electronic patient system.
- Recruitment to community staffing was highlighted as a concern and managers were using different strategies to address this. Staffing was on the risk register. Staff we spoke to felt caseloads were manageable. Therapy staffing had few vacancies and the actual staffing levels versus planned was good. Community nursing staffing data showed the whole time equivalent against the planned staffing levels to be similar.
- Staff base buildings were highlighted on the risk register and staff told us of the challenges of being based in such buildings. Lack of access to IT was found to be an issue in some areas of community services. This was highlighted as a risk and managers were actively seeking a mobile solution to allow access to the required systems.
- There was good evidence based care and treatment using national and local guidance. We saw person centred care and the use of risk-based tools through the electronic patient system. Patient outcome data was collected and community services participated in a number of audits.
- Staff had received the appropriate training and development. Learning needs were identified during annual appraisals, staff told us they had access to further training, and development was good.
- Patients received compassionate care and their dignity and privacy was respected. Staff interacted with patients and provided the emotional support required. We found staff had a strong sense of patient understanding and staff involved patients, families and carers where appropriate.
- Feedback from patients and carers was consistently positive. Community services sought feedback from patients and carers and the walk in centres actively engaged with the public.
- The culture in the community teams was one of teamwork and supporting each other. Management were found to be visible and supportive. There was a clear strategy in place for community services for adults. The strategy had yet to be implemented fully. Governance arrangements were in place and a clinical governance data pack included a clinical assessment tool, care summary data and patient outcome data.

# Summary of findings

## Background to the service

The Newcastle Upon Tyne Hospitals NHS Foundation Trust was the main provider of community health services for adults in Newcastle. Community services were provided in people's homes, community clinics, GP practices and walk in centres.

Community services for adults included community nursing services or integrated care teams, district nursing, community matrons and specialist nursing services, therapy services, intermediate care, rehabilitation services and walk in centres. The district nursing service was a 24 hour/7 days a week service. Community services integrated with the Newcastle Hospitals Trust in 2011 and have been in a period of transition and development since then. The district nursing teams consisted of a team of district nurses and healthcare assistants that were split into four clusters around Newcastle. Each geographical area was managed by a cluster co-ordinator. The four clusters were Inner West, North, Outer West and East. Each district nurse was associated with a local GP practice. The Chronic Obstructive Pulmonary Disease

(COPD) community service was based at the Royal Victoria Infirmary. Community services included a community response and rehabilitation team with a rapid response service focused on admission avoidance.

The community service directorate managed three nurse led walk in centres at, Lemington, Westgate and the Molineux walk in centre.

Therapy services included Physiotherapy services, Occupational therapists, adult speech and language therapy, community psychology and podiatry. Therapy services were based in a number of buildings around Newcastle. Community Psychology were creating an alliance with the improving access to psychological therapies (IAPT) service in the near future.

We spoke to 64 staff across community services; we spoke to 16 patients and carers and reviewed 36 care records, which were a mixture of paper based records, and electronic records.

## Our inspection team

Comments from patients, carers and families were positive throughout our inspection.

Comments included 'very good' when referring to community services.

## Why we carried out this inspection

Our inspection team was led by:

**Chair:** Ellen Armistead, Deputy Chief Inspector, Hospitals, Care Quality Commission

**Head of Hospital Inspection:** Amanda Stanford, Care Quality Commission

The team included CQC inspectors and specialists including a community matron and a service manager (physiotherapy).

## How we carried out this inspection

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

# Summary of findings

## What people who use the provider say

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 hold about the core service and asked other

organisations to share what they knew. We carried out an announced visit on 19th to 22nd January 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 5th February 2016.

## Good practice

- The community Chronic Obstructive Pulmonary Disease (COPD) team worked closely with the North East Ambulance Service. When a patient exacerbated, the ambulance staff could contact the COPD team and they attended the patient within the hour.
- A seamless, comprehensive and inclusive service to all patients had been developed by identifying four distinct service pathways for mild, moderate, severe types of stroke as well as one for long-term support and management. Each pathway within the model was tailored to meet patient need with optimum use

of resources to maximise individual's post stroke health maintenance, promote independence and quality of life as well as reducing re-admission to hospital and social services care requirements.

- The community team had developed a pressure ulcer care plan and pressure ulcer checklist for housebound patients nursed at home. The care plans detailed essential assessments required and involve family and carers in the delivery of care in order to reduce the incidence of pressure ulcers nursed at home.

## Areas for improvement

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

- Ensure that there are appropriate adaptations for patients with hearing difficulties in the community walk in centres.

- Ensure that there is a formal escalation procedure for staff to follow in the event of patients deteriorating at the walk in centres.

## The Newcastle-upon-Tyne Hospitals 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 community health services for adults good for safe because:

- Staff we spoke to had a good understanding of safeguarding and knew how to report safeguarding concerns.
- Staff told us they reported incidents regularly through the appropriate systems and staff normally received feedback regarding the outcome of incidents. Incidents were discussed at team meetings and management meetings. There was evidence of learning, for example, providing training on tissue viability to care homes and training on pressure care documentation.
- We found good levels of hygiene and equipment, once used, being cleaned. We found the storage of medicines to be appropriate with the required security in place for medicines.

- While there were vacancies across the different teams, staff told us their caseloads were manageable and the teams managed their caseloads locally. There were no formal caseload management tools or staffing acuity tools in place. There was a good level of skill mix amongst staff with many staff having completed further training, independent prescribing courses and specialist qualifications relating to their field.

### Safety performance

- The community services for adults' directorate participated in the NHS Safety Thermometer. The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysis of, patient and harm free care. The tool monitors pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE).
- The safety thermometer data showed there were no falls with harm (level 4 or 5) and no catheter-associated urinary tract infections between 1st November 2014 and 31st October 2015.



## Are services safe?

- There were between 10 to 30 pressure ulcers (grade 2 – 4) incidents reported each month through the safety thermometer between October 2014 and October 2015.
- There have been no never events in the last year for community services for adults. Never events are serious incidents that should not occur if the appropriate preventative measures were taken.
- There have been no serious incidents reported between 1st November 2014 and 31st October 2015.
- There have been no deaths or severe harm incidents between 1st November 2014 and 31st October 2015.
- There were a total of 980 incidents reported through the national reporting and learning system in community services between 1st November 2014 and 31st November 2015.
- We reviewed minutes from the monthly community health team brief and found learning from incidents and improving patient safety to be an agenda item.
- Minutes from the therapy services clinical governance meeting showed incidents were on the agenda along with learning and trends.
- Incidents were investigated and, in the tissue viability team, we saw an example of a root cause analysis and the action taken to learn from the incident. Actions taken included providing training to the care homes and training on documentation.
- Staff in the community stroke team told us they were implementing reflection statements for staff to complete when an incident had occurred. No reflection statements were available, as this had recently been implemented.

### Incident reporting, learning and improvement

- The trust had safety systems in place to report incidents and near misses. Community services had access to the online incident reporting system. Access to the incident reporting system at the Lemington walk in centre was not possible because the systems at Lemington did not connect to the Newcastle Hospitals systems. Staff at Lemington walk in centre had to complete incident report forms at the Westgate walk in centre if required.
- Staff we spoke to knew how to report an incident through the electronic recording system. The electronic system had a section where you could request feedback regarding the incident. Staff told us they normally received feedback from reported incidents if they requested this.
- Staff at the tissue viability service explained that pressure ulcers of grade 3 and above were documented as serious incidents. We found that all pressure sores and moisture lesions were being recorded as incidents. Root cause analysis was carried out in the form of a mini root cause analysis and this determined if a full root cause analysis was required. The electronic patient system had a section for action plans for pressure ulcers. We saw an action plan that had: issues identified, contributory factors, and actions to be taken.
- Learning from incidents and clinical governance data packs were discussed and shared at management meetings. Each team in the community was represented at each governance meeting and the shared learning was fed through to other staff by the representative.

### Duty of Candour

- The Duty of Candour was introduced as a legal requirement for National Health Service (NHS) trusts in November 2014. It is about trusts informing and apologising to patients if they have made a mistake in their care, which led to a moderate or significant harm.
- We found staff understood the Duty of Candour and staff were able to explain candour, openness and being honest.
- Community services had a leaflet called “Duty of Candour (Being Open and Honest)” which was a guide for patients and their relatives who have suffered serious harm while receiving care.
- There was a “Being open (Duty of Candour)” policy in place. This was in date and accessed on the trust intranet.

### Safeguarding

- Safeguarding adults and children was part of the trust mandatory training for staff. Staff we spoke to confirmed they had completed this training.
- Safeguarding training records showed that 92% of staff had received safeguarding for adults level 1 training and 94% of staff had received safeguarding for children level 1 training. The trust target was 95%.
- Staff had a good level of understanding of safeguarding procedures and how to report safeguarding concerns throughout community services.
- Staff we spoke to understood who to contact with safeguarding concerns and felt comfortable doing this.

## Are services safe?

- Staff we spoke to provided examples of safeguarding concerns and incidents and how they were reported and acted upon.
- There was a safeguarding policy in place. This was accessible through the intranet.

### Medicines

- The district nurse teams did not carry medicines.
- District nursing teams had good communication and team working with local pharmacists and GP practices. District nurse staff told us patients were prescribed medicines at their GP practice and then collected their medicines from a local pharmacy.
- We observed staff assisting patients and carers in the management of their medicines.
- We observed nurses checking patients' current medicines and checking with patients and family if they understood how to take the medicines.
- Patient Group Directions (PGD) are written instructions that permit the supply or administration of medicines to patients. We looked at a number of PGDs and all were in date and signed. Examples included the seasonal influenza vaccine, Shingles and pneumonia. The district nursing teams and walk in centres used PGDs.
- Medicine cupboards were locked. Two nurse practitioners signed the keys in and out at the start and end of each shift at the Molineux walk in centre.
- We checked several of the medicines in the cupboards and all were in date. Staff rotated medicine stock regularly. Prescriptions were securely stored in the medicine cupboard.
- Top up of the medicine cupboards was completed using a stock sheet.
- Oxygen storage was appropriate with safety data sheets on display. An external provider checked oxygen at Lemington walk in centre every six months. We saw the latest document signed and dated.
- Refrigerator temperatures were checked and recorded daily.

### Environment and equipment

- We found the majority of staff bases to be of a suitable standard. However, concerns had been raised regarding the Allendale staff base about maintenance and suitability. Staff bases were included on the risk register with a plan to involve estates when issues were identified.

- Security of staff at walk in centres was highlighted on the risk register. The Lemington walk in centre had a panic button available for use through the electronic system in the administration office. The clinic rooms had a panic button. Testing records for clinic panic buttons were not available, as the building was not owned by Newcastle Hospitals.
- Equipment checked was found to be PAT (Portable appliance testing) tested.
- Staff told us they had timely access to equipment. Geoffrey Rhodes centre was the central location for the loan of equipment.
- We saw posters on walls showing waste segregation and disposal guidance.
- We checked the defibrillator records in the community cardiac cardiology team and records showed they were checked yearly and were up to date. We checked a defibrillator against the records and the physical sticker matched the online spreadsheet record showing it was serviced in December 2015 and was due for the next service in December 2016. One defibrillator on the spreadsheet was marked overdue but we were informed this was not in use anymore.
- Resuscitation trolleys were checked daily in the walk in centres and found to be PAT tested; the log showed it was signed for each day and up to date. We found two missing entries for checks on the resuscitation trolley at the Westgate walk in centre. This had however, been checked daily since the missing entries. There was a medical device register.

### Quality of records

- Patient records were held on an electronic patient system and in paper format. Patients had paper records in their homes. Staff would complete the paper records during visits and then update the electronic system on arrival at the office.
- Access to patient system records was a challenge for services such as pain management where they had clinics in different settings and system records were not always accessible. Staff told us they securely store and transfer notes between sites and if required off site to ensure they are available for the next clinic or day.
- We reviewed care plans across the different teams and locations across community services and found these to be appropriately completed. We looked at 36 health care records which were a mixture of paper records and electronic records.

## Are services safe?

- We looked at care plan accountability forms and all were signed and complete.
- Staff in district nursing showed us how they were able to use markers on the electronic system to highlight relevant information regarding patients.
- We saw a patient diary audit carried out six monthly by the district nurse teams. One diary audit showed out of 34 staff that completed the audit, one entry was missing due to sickness and one entry was not completed.
- The community response and rehabilitation team had completed an audit of notes in September 2015. The audit contained a section on the results, recommendations and an action plan. The action plan did not specify dates for the actions to be completed. Other audits seen did have action plans in place with the person responsible noted and action by date. An action plan seen for an audit within the community response and rehabilitation team showed an action due by January 2015 had been completed.
- District nursing carried out a records audit in 2015/2016. Each district nursing cluster was involved and examples of the results show that 100% had recorded the patients full name, address and date of birth.
- The trust target compliance rate for mandatory training was 95%. The current community services completion rate for mandatory training was 89%.
- Resuscitation adult basic life support mandatory training completion rate was 69%. Records showed not all staff had up to date training on resuscitation adult basic life support.
- Statutory mandatory training was a mixture of e-learning and classroom sessions. Areas of community services had found challenges in accessing the trust e-learning system. Management had responded to this and organised face-to-face training where necessary.
- We reviewed a number of training records at the services we visited and all were complete and up to date.
- The online system used to record training requirements was not always accurate and sometimes reflected required training to staff that did not need it.
- The system flagged as false if the training was not complete and true if complete.
- The trust had an in date mandatory training policy that could be accessed through the intranet.
- There was a community services training matrix in place to identify staff mandatory training requirements.

### Cleanliness, infection control and hygiene

- Walk in centres were clean and tidy.
- We found the standards of cleanliness and hygiene to be good. The walk in centres had hand gel dispensers available on entry to the walk in centres.
- During home visits, we observed staff using hand gel prior to seeing the patients and following the 'bare below the elbows' guidance.
- We observed staff cleaning equipment after use.
- We found that 91% of staff had completed infection prevention and control training.
- The community infection control team produced quarterly community environmental audit reports (CEAT). The audit aims to provide assurance that the patient/client environment and standards of cleanliness adhere to infection prevention and control standards. The CEAT process involves completing inspections. An example of data from the July – September 2015 audit showed the Kenton centre received an overall rating of 78%. Recommendations were made following the audit outcome.

### Mandatory training

### Assessing and responding to patient risk

- Staff explained examples of care, which was in response to patients risk changing and requiring further assessment and response. We heard of examples where staff had responded to patients deteriorating needs and worked with other healthcare professionals to address the concerns and re-evaluate the treatment for patients.
- We saw staff using the communication sheets in care plans to monitor patient risk and provide clear up to date information on patients care.
- Staff told us of a variety of risk-based tools being used throughout community to assess patient risk and requirements. Examples being the Braden assessment, a risk assessment tool used to assess a patients risk of developing a pressure ulcer. Braden assessments were found to be in use in patient records where required.
- Community teams used the Emergency Admission Risk Likelihood Index (EARLI). EARLI is an evidence-based tool used for predicting the likelihood of emergency admission of people over 75 to hospital.
- Administrative staff for district nursing took incoming calls and then referred onto the community nurse if urgent or entered it onto the electronic system as a

## Are services safe?

referral if not urgent. There was an informal understanding of what to do. Administrative staff could explain what must be referred to a nurse and what was non-urgent; however, there was no formal procedure for managing incoming referrals to the district nursing teams.

- We observed the COPD team speaking to patients about managing their condition and services available to them.
- The community cardiology team used a risk factor sheet, which was used to identify potential risk about heart attacks. This document was regularly reviewed and goal planning was taken into account. Staff we spoke to described how they would try to involve the patient in their goal planning.
- Walk in centres did not have a formal procedure for patients who deteriorated in their care and required referral to hospital. Staff told us they would call 999 if a patient deteriorated in their care. Staff did provide examples of where patients presented at the walk in centre and required urgent referral to hospital: staff called 999 and completed an incident form.
- The community stroke team discussed patients requiring complex care at their team multi-disciplinary meeting.

### Staffing levels and caseload

- Staffing levels across community services showed that the planned staffing levels and actual staff levels were mostly as planned but recruitment was found to be a challenge. The overall vacancy rate in the community was 9%. This was double the trust average.
- Staffing levels in therapy services were mostly as planned. The planned whole time equivalent (WTE) was 182 and the actual was 173.
- Staffing levels in community nursing were mostly as planned. The planned WTE was 149 and the actual was 146. District nursing planned WTE was 127 and the actual was 125.
- The walk in centre staffing planned total was 18 WTE and the actual was 18. There was no data available for the Lemington walk in centre planned versus actual staffing level.
- Staff acknowledged at all levels that recruitment to district nursing was a challenge. The trust had responded to this risk by using social media and being able to over recruit to posts. The community strategy described the current position and acknowledged the

challenges faced. The strategy provided an example of how the service could manage this challenge such as exploring the ability for nurses to work across community and acute pathways.

- Staff we spoke to felt caseloads were manageable. Staff explained they discussed caseloads within their teams and shared the caseloads amongst the team. Caseloads were found to be managed through the electronic patient recording system or through diaries.
- Community services rarely used agency or bank staff and when they did, they tried to use the same staff who had previously worked there. Bank and agency staff went through the same induction and training process.
- There were no formal staffing acuity tools in use.
- Caseloads for district nursing were managed at local level by the cluster co-ordinators for the four districts.
- Walk in centres had a minimum staff level of two nurses. Staff mitigated risk to patients by triaging patients over lunchtime to assess risk during times of low staffing levels. During our visit to the Lemington walk in centre, there was only one community nurse on duty due to sickness. This had been discussed and agreed with managers. Lemington is a part time walk in centre open from 13:00 – 16:30 three days a week. There was no staffing escalation procedure in place for staffing shortages.
- The COPD service, community heart failure, community stroke, tissue viability, community continence and community response and rehabilitation team had a full staffing compliment.
- The community strategy proposes that a case manager role to be developed within each primary care team to work with GP practices to deliver case management to the most complex patients at risk of readmission/ admission to hospital.

### Managing anticipated risks

- The community response and rehabilitation team had funding for two extra bank nurses for a three-month period to cover winter.
- The trust had a “Maintaining Services during Adverse Weather Conditions and Public Transport Disruption Policy” in place, which described the responsibilities of the employee and their manager during potential times of disruption due to adverse weather conditions.

## Are services safe?

- There were business continuity plans in place for the walk in centres, the tuberculosis service, specialist care home support team, district nursing, community matrons and community rehabilitation.

# 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 community health services for adults good for effective because:

- There was continuous use of evidence based care and treatment throughout the community adults services. We found a number of examples of national and local guidelines and procedures being followed as well as adherence to National Institute of Health and Care Excellence (NICE) guidelines. Specific services used their speciality guidance on a number of occasions.
- There was good multi-disciplinary working amongst the different community teams, social worker services and GP practices with each district nursing cluster associated with a GP practice. This had led to strong multidisciplinary team working and communication between the services.
- The community service directorate had an audit plan in place for 2015/2016.
- We found many staff to be highly skilled and competent in their respective areas and staff continually learnt new skills and identified training needs. Staff told us they had annual appraisals and this was an opportunity to discuss their learning needs. Access to training and further development was good.
- Staff told us they had regular clinical supervision.

## Evidence based care and treatment

- National and local guidance was used by the community services for adult's teams to assist in the care of patients. National Institute for Health and Care Excellence and team specific guidance was used.
- We saw evidence of good practice information available for staff. For example, the physiotherapy team had a folder with good practice guidance noted throughout.
- We saw various examples of evidence based care treatment within the COPD service. Examples included the north Tyne COPD treatment guidelines/NICE guidelines and British Thoracic Society guidelines.
- We saw a number of examples of clinical tools being used to assess patients. Examples included a sepsis tool, Deep Vein Thrombosis (DVT) tool and the Pharyngitis score.

- Staff could explain how they worked with patients to set outcome goals and actively involve patients in setting treatment goals.
- We saw a Comprehensive Aphasia Test (CAT) being used in the speech and language therapy team. Staff were able to discuss evidence-based practice.

## Nutrition and hydration

- There were booklets available for patients called "eat well and feel stronger".
- There was access to a nutritionist if required and a malnutrition scale was available.

## Technology and telemedicine

- Mobile working was not implemented in the community services settings. There was a pilot currently being undertaken in one of the services for mobile working.
- An electronic records system was in place to record patient details and conduct risk assessments through tools provided in the system. An example was the pressure ulcer assessment tool.
- The speech and language therapy team were using a technology-based tool for voice treatment in patients with Parkinson's. The implementation of this technology had improved their services.
- Access to trust information technology was a challenge amongst some staff. Lemington walk in centre had no access to the trust intranet.

## Patient outcomes

- The COPD referral rates showed that 40% of referrals were from general practitioners and 40% from self-referral showing patients were self-managing their conditions.
- The Sentinel Stroke National Audit Programme (SSNAP) is an audit programme, which aims to improve the quality of stroke care against evidence-based standards and national and local benchmarks. The community stroke team participated in this audit. The trust had an overall level B in April – June 2015. The trust had a level

## Are services effective?

A for physiotherapy for April – June 2015, a level of E for speech and language therapy for April – June 2015 and a level C for occupational therapy for April – June 2015. Level A is the highest level available.

- Waiting time targets for the Westgate walk in centre, Lemington walk in centre and Molineux walk in centre were four hours from patient arrival to discharge. A walk in centre audit conducted at the Molineux and Westgate showed the above targets were being met each month during the audit. The audit was carried out between January 2015 and December 2015. There was no data available for the Lemington walk in centre.
- The community response and rehabilitation team had implemented a patient outcome system. Data from November 2015 showed 5% of patients had deteriorated, 6% had no change and 89% had improved. Data was positive showing that 89% of patients had improved in September, October and November 2015.

### Competent staff

- A number of staff we spoke to told us the training and development opportunities offered by the trust was good.
- 80% of appraisal reviews were complete. All staff we spoke to had an appraisal in the last 12 months. Staff described the appraisal as an opportunity to set training and learning goals for the next year.
- Clinical supervision is a formal process and professional support and learning that addresses a practitioners needs. Staff were able to describe the arrangements for clinical supervision.
- We found there to be a good level of skill mix between the staff. An example within district nursing was the use of link nurses. Another example of skill mix and developing competent staff was within the speech and language therapy service where a dual post of administrative/assistant therapist was being trialled. This enabled the service to be flexible.
- Management told us a capability procedure was in place to assist in addressing variable staff performance.

### Multi-disciplinary working and coordinated care pathways

- Care was delivered in a way which involved the necessary teams and services and there was regular and clear communication between the different teams and

services regarding patient care. The community service teams and other healthcare professionals worked together to support patients and facilitate person centred care.

- Care pathways were in place and staff could describe the anticipated requirements for patients accessing their care.
- The community response and rehabilitation team were co-located with social care teams and this had enhanced communication channels between the different teams.
- The community nursing clusters were attached to GP practices to facilitate multi-disciplinary working. There was clear joint working between the nursing teams, GP practices and pharmacists.
- The pain management service had regular multi-disciplinary team meetings involving a number of healthcare professionals.
- Pain management had developed a service with a local GP practice to allow patients rapid access to see a GP for pain management services.
- The community psychology service was currently reviewing their care pathways in anticipation for the newly created alliance with the IAPT service.

### Referral, transfer, discharge and transition

- Referrals into community health services for adults came from a variety of sources such as GP's, self-referral, the acute hospitals and referrals from other community services.
- Systems were in place to manage referrals. Community health services worked closely with a number of other services and the different services could explain their criteria for referrals into their services.
- District nurses provided an example of how they helped to facilitate discharge of a complex patient from the hospital to home by attending the hospital to discuss arrangements before discharging the patient into the community.
- The community tissue viability team had clear referral criteria. Level 1 (non-complex – telephone advice), level 2 (routine or chronic – 2 week response) and level 3 (complex care – 3 days response). Staff told us they met these targets.

## Are services effective?

- The community stroke team were part of a joint stroke steering group with the acute team. To facilitate discharge the community stroke team attended the acute multi-disciplinary team meeting to discuss patients being discharged into the community.

### Access to information

- Staff told us that since the integration with Newcastle Hospitals Trust, information sharing had improved.
- The district nursing teams used an electronic patient management system and paper records to record information. Sharing information with GP practices and other professionals was good where they used the same system. In the cases where different systems were used, a Fax was used to transfer information. Staff said they always checked the fax had been received by the recipient once sent.
- We saw information leaflets in the clinic areas and reception areas. We found community teams often carried the leaflets to provide to patients when being treated at home.

- There was a duplication of work and uploading of information. An example being staff would complete the paper care plan and then return to the offices to re-enter the information onto their electronic systems.
- A multi-agency information sharing protocol was in place dated August 2015.

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

- Community services had a multi-use consent form in place, which allowed patients to consent to a number of actions such as treatment and the sharing of their information.
- Consent was sought in line with relevant legislation and guidance.
- We heard examples where consent was sought. There was a consent policy in place.
- Staff in the district nursing teams had an awareness of best interest meetings and involving other professionals if required. They could explain taking people's wishes into account.
- Staff had an awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.



## Are services caring?

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

### Summary

We rated community health services for adults for caring as good because:

- Patients and carers were positive about the care and treatment they had received.
- We observed compassionate care that showed staff treating patients with dignity, respect and kindness.
- Staff throughout community services were seen to have a good understanding of their patients' needs, and provided the appropriate communication to patients and carers. Staff understood emotional support requirements for patients living with long term conditions and provided emotional support to patients and carers.
- We heard examples of patient privacy and patient preferences being respected.

### Compassionate care

- We observed staff involving patients and families in their care, explaining the care plan and checking patients understanding of the treatment. Staff took the time to interact with patients, carers and their families.
- Patients, carers and families we spoke with were very complimentary of the care received and positive about the care provided by the community services teams. We spoke to 16 patients and carers.
- Friends and family test data from December 2015 showed 100% of respondents would recommend the community services directorate. There were 31 responses in December 2015.
- A patient feedback questionnaire for the chronic obstructive pulmonary disease team showed 80% of respondents felt the overall support from the team was very good and 17% felt it was good. 213 questionnaires were sent to patients with a response of 64%.
- We heard of an example where the walk in centre staff had supported a patient in the transfer to hospital.
- During consultations and patient visits, staff were professional, respectful and supportive to patients and their families.

- We heard examples where patient privacy was observed and the wishes of the patient taken into account during treatment. Staff respected patient's privacy, dignity and confidentiality when care was being provided.
- Staff took into account cultural, social and religious needs when delivering services to patients.

### Understanding and involvement of patients and those close to them

- We saw staff communicate with patients in a clear way and taking the time to understand patients current needs and gather the view of the family and carers involved.
- Carers told us they were fully involved in the treatment and care of the person involved. A care plan we checked contained a carer's plan, which took into account carer's needs.
- Staff spoke with patients and carers about their care and treatment during visits and offered additional information on services available to the patients.

### Emotional support

- Staff we spoke to understood patients' needs and provided support to patients during their care and treatment.
- Staff in the community cardiology team were able to describe how they encouraged patients to assist in setting their goals in a care plan. The community cardiology team used an anxiety depression scale to assess patients. Staff were able to describe what to do if the scale showed deterioration in a patients emotional state. Staff were able to refer to psychology if required.
- We observed staff speaking with the family and carers of patients about their care in a sensitive way. Staff were seen to provide good emotional support to carers and families and understood the emotional effects a patients care can have on those close to them.
- Staff empowered patients to manage their health and manage their medication. Patients and their carers had medicines explained to them and were encouraged to self-manage.

# 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 community health services for adults good for responsive because:

- The services reflected local population needs. For example, district nursing services associated with GP practices were based on population numbers.
- The service had an understanding of commissioning arrangements and the challenges faced.
- The walk in centres were suitably equipped to meet the needs of patients with the appropriate disabled facilities, reception areas and clinic rooms. There was good access to interpreter services.
- Patients received timely access to initial assessment, diagnosis or urgent treatment. The service took action to minimise the time patients had to wait for care and treatment.
- There was a complaints system in place and learning from complaints was seen.

## Planning and delivering services which meet people's needs

- District nursing reviewed the local population to assess the requirements for their services and number of district nurses required for each GP practice. The district nursing team operated 24 hours a day/7 days a week.
- There was clear engagement between the different healthcare professionals to deliver services to meet people's needs. An example was the engagement between the acute services and the community and the district nurses and GP practices.
- Managers were able to discuss the services and planning they undertook and describe working closely with commissioners, general practitioners, acute and community services and patients.
- Services were flexible to people's needs and on community therapy and nursing visits we saw good levels of continuity of care being provided.

## Equality and diversity

- We heard that there was a system for access to translation and sign language services. Staff told us this

was an effective service and available when required. Staff were able to describe instances where they required translators to assist in the care they were giving.

- Molineux, Lemington and Westgate walk in centres had wheelchair access and disabled toilets were available.
- There was no hearing loop at the Molineux or Lemington walk in centres for people with hearing impairment.
- Equality and diversity training was part of the mandatory training programme. Community services had a 94% compliance rate.

## Meeting the needs of people in vulnerable circumstances

- Staff at the Molineux walk in centre told us they could contact the learning disability nurses and Mental Capacity Act nurses at the trust if required. Staff said they provided excellent support and were easy to contact.
- Community service staff told us they had access to learning disability link nurses. Some staff also told us they had completed learning disability training.
- Staff had an awareness of meeting the needs of people in vulnerable circumstances and involving the appropriate professionals in care and treatment. Staff could describe working with learning disability nurses and safeguarding teams when needed.
- Staff told us they had good links with social workers and could refer and contact social worker teams when required.
- The COPD team had received dementia updates and this was cascaded to the wider teams. They could clearly describe the "forget me not" scheme.
- Patient information leaflets were available at services visited. These leaflets included a community matron and district nursing service leaflet with details of the services and referral criteria.

## Access to the right care at the right time

- We found that patients had timely access to care throughout the community services directorate for adults.
- The NHS aims to have a maximum wait from referrals of 18 weeks. All community services for adults average wait

## Are services responsive to people's needs?

time from referral was within this target based on data collected over six months. Examples of this data include an average wait time in weeks for the Newcastle speech and language therapy team of 1 week in September 2015 and an average wait time in weeks for the Newcastle domiciliary physiotherapy service of 8 weeks in September 2015.

- The community response and rehabilitation team provided a single point of access rapid assessment to patients to focus on re-admission avoidance. Data showed 95% of all urgent referrals were responded to within two hours within the community response and rehabilitation team in December 2015.
- We found there to be good links between the different healthcare professionals and good access to other community services.

### Learning from complaints and concerns

- The community newsletter “take 2 minutes” described learning from complaints. An example of the summer 2015 “take 2 minutes” informed patients there was a complaints booklet available on the internet in five languages and in British sign language.
- Complaints were discussed at the directorate meeting and details were included in the community directorate clinical governance data pack. The background to the complaint, learning points and an action plan was documented in the clinical governance data pack.
- Staff provided examples of how they managed patient complaints. An example showed staff provided patients with a leaflet detailing complaints, how to make them and the details of Patient Advice and Liaison Service (PALS).
- The Lemington walk in centre had a folder located in the waiting area, which contained information on how to make a complaint and contact PALS.
- There were 15-logged complaints from May 2015 to January 2016. The clinical governance data document contained information showing PALS reports and a complaints section. This had a learning points section included. We looked at monthly team briefs for community health and found complaints to be a standing agenda.
- We looked at team meeting minutes from the community response and rehabilitation team and complaints were an agenda item.
- We saw a complaints action plan with learning identified and actions documented. We also saw complaint action plans in place for the walk in centres and the community response and rehabilitation team.

## 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 community health services for adults good for well-led because:

- The service had a clear strategy, which set out the vision for community services and the current position. The community services strategy included national guidance as part of its vision and provided improvement and development ideas to respond to the challenges faced in community services.
- Management had access to a clinical governance data pack that was discussed at management meetings and included quality and governance reports. We found there was an appropriate level of access to quality and governance information.
- There was an audit plan in place for 2015/2016. Management were able to discuss the risks community services for adults faced.
- We found there were good levels of engagement between staff and management and staff we spoke to felt valued and well supported. Management were accessible, supportive and had an “open door” policy for staff. Staff we spoke to felt able to raise concerns and understood how to do this. We found a strong culture of teamwork, teams that supported each other and good levels of communication between community service teams.
- Staff told us there were good opportunities for continuous learning and development and staff goals were discussed at annual appraisals. Lack of access to some IT systems was described as a challenge for community services. We were told one area of community services were piloting a mobile working solution.

### Service vision and strategy

- We saw trust values displayed in clinics and staff bases throughout community services.
- Community services had a strategy plan dated from September 2015. The strategy clearly described the vision for the service. The strategy detailed the current position and the proposed model of care along with a vision that took into account an integrated care model,

partnership working and placing the patient at the centre of care delivery with services designed around their needs. The vision and strategy takes into account national guidance such as the five-year forward view.

- Therapy services had a three-year strategy in place, which included the vision, strategic goals, and business strategy.
- Staff we spoke to had a clear idea of their roles and were able to describe their services. Staff told us they felt involved in the development of services.

### Governance, risk management and quality measurement

- Community services had a clinical governance data pack, which was presented at management meetings. The data pack contained information on incidents and complaints, shared learning from incidents, PALS reports, action planning and the pressure ulcer dashboard.
- There were processes to monitor risk through audit. Audits were registered on the clinical effectiveness register.
- A clinical assessment tool (CAT) was in place to monitor environmental cleanliness, Assurance measures, clinical assurance and staff knowledge. Results from the December 2015 scorecard show 100% for environmental cleanliness in all areas, 97% for assurance measures, 98% for clinical assurance and 96% for staff knowledge.
- The clinical director for community services was the nominated clinical governance lead.
- The service used a risk register, which detailed the risk, what controls were in place and the progress of the actions. Management were able to describe some of the action being taken to mitigate the risks. An example being district nurse staffing and the use of social media to recruit along with specific recruitment into community district nursing.
- We saw a service quality and performance report in place highlighting operational standards/ national quality requirements, local quality requirements and a data quality improvement plan. This report was published monthly.

# Are services well-led?

## Leadership of this service

- Staff told us management were visible and approachable. The community services for adults nursing lead held a monthly staff surgery, which allowed staff to drop in and discuss any concerns, challenges or work with management. This had been seen to work well and be positive since it started in early 2015.
- Staff provided examples of good opportunities to study further. An example provided was staff completing postgraduate study and management and leadership courses.
- Staff had access to a variety of leadership courses provided by the trust and external bodies.

## Culture within this service

- Staff we spoke to described a culture of teamwork and strong team ethic. Staff felt respected and valued by the trust and community services.
- Staff we spoke to felt well supported by management and explained that management had an open door policy. Staff felt able to raise concerns.
- Community services had a lone working policy. We saw a mixture of two systems being used for lone working. Some staff used a telephone call in and out system and other staff groups used a diary to record where they were going so the team knew where they were. Staff were confident the teams knew where each other were throughout the working shift.
- Staff we spoke to were proud to work for the service and enjoyed their positions and roles.
- We spoke to staff throughout community services who explained research and training was encouraged.
- Community services for adults merged with Newcastle Hospitals in 2011 and staff told us at first the integration was a challenge but had since improved. Communication between the community directorate and the acute setting was noted as a benefit to the integration.

## Public engagement

- Services we visited during the inspection carried feedback cards to gain feedback from patients. An example being the community response and rehabilitation team feedback form.
- COPD patient survey results from 2015 show that 80% of patients received very good support from COPD services.

- The community response and rehabilitation team sought patient feedback through a questionnaire available to patients to describe their recent experience of the service.
- Community services engaged with the public and patients and asked for feedback through questionnaires. An example of the engagement was within the community musculoskeletal outpatient physiotherapy team. They had a back assessment questionnaire for patients.
- The community stroke team had been involved in a patient carer event. The team sent questionnaires to patients. They sent 199 and 85 questionnaires were returned. The responses were positive.
- The community stroke team were represented at an event called 'Newcastle upon Tyne Stroke Services World Café Event'. The event included a discussion with patients and carers about the positive aspects of the service, what could be done better and how to raise stroke awareness in the public.
- The pain management service had an annual conference for patients. Patients were invited to complete questionnaires.
- Staff from the walk in centres planned to attend a cultural festival to show what services the centres offered. Staff also attended community events.

## Staff engagement

- Therapy services had an annual therapy services celebration conference, which proved to be positive. Staff had the opportunity to apply for innovation awards.
- Therapy Matters was a therapies newsletter, which was available in hard copy and by email and detailed news in the therapies directorate, notable achievements and provided a platform for therapy services to share their information.
- We saw documentation, which allowed staff to nominate other staff for excellent and compassionate care within the community response and rehabilitation team.

## Innovation, improvement and sustainability

- We found evidence of service improvement in the community COPD team. An example was the development of a service between the North East

## Are services well-led?

Ambulance Service and the COPD team. When a patient has exacerbated, the ambulance staff could contact the COPD team and they attended within the hour to the patient.

- Community services were piloting mobile working.
- The pain management service had set up a service user group, which invited users of the service to attend and ask patients for their input on service development. Service users were able to sit in on interview panels and provide their input.
- The pain management service had implemented a mindfulness programme for service users where patients received a two-hour session and a programme to take away. Feedback from this service was positive.
- The community stroke service had developed a comprehensive stroke service model. Community stroke had implemented a care pathway model, which took into account the complexity of the patient. There was a designated team assigned to patients being discharged in under 15 days and a designated team that were assigned to patients being discharged after 15 days.
- The community psychology service had appointed cognitive behavioural therapists, which had led to a development of their service and extra expertise within the community psychology team.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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