Northamptonshire Healthcare NHS Foundation Trust

RP1

Community health services for adults

Quality Report

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

Summary of findings

Ratings

Overall rating for Community health services for adults	Requires Improvement 
Are Community health services for adults safe?	**Requires Improvement** 
Are Community health services for adults effective?	**Requires Improvement** 
Are Community health services for adults caring?	**Good** 
Are Community health services for adults responsive?	**Good** 
Are Community health services for adults well-led?	**Good** 

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for community health services for adults required improvement because:

The trust management had ensured that learning from serious incidents was shared with front-line staff. This meant that these staff members had the benefit from the results of investigations into the incidents. Staff were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service. The service had taken action to reduce new pressure ulcers and slips, trips and falls. The environment was clean and staff followed the trust policy on infection control.

Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, in pain management, and the monitoring of nutrition and hydration of patients in the perioperative period. Multidisciplinary working was evident. Patients told us that staff treated them in a caring way and were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect.

The medical staffing was appropriate and there was good emergency cover. However, there was a shortage of nursing staff with a high number of vacancies.

Staff had access to training and had received regular supervision and annual appraisal. Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

National waiting time targets for Referral To Treatment (RTT) for 18 weeks for those services applicable to the trust were being met. There were longer waiting times for the dietetic service. Services were being developing to improve response to increasing demand. There was a high number of delayed transfers of patients ready for discharge. This was due to delays in accessing care home or care packages. There were various inefficiencies in discharge arrangements for patients. This resulted in patients being discharged without the prior knowledge of the community teams.

There were long waiting times of up to eight months for patients referred for physiotherapy classed as non-urgent which did not meet the clinical commissioning groups' two week to referral appointment times. Patients at the surgical podiatry service at Battle House had an average wait of between six to nine months from assessment to referral to surgery time.

There was support for people with a learning disability and reasonable adjustments were made to the service. But information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were dealt with.

We found that community services were well-led. There was positive awareness among staff of the values and expectations for patient care across the trust. Some staff said they felt pressurised when patient referral fluctuated and some felt that they received poor support during stressful periods. The services had identified the risks and had action plans and outcomes in place to manage this risk.

Despite the work pressures, staff were compassionate, sensitive and kind to people who use the service. Service managers provided good leadership and were visible and accessible to both people who use the service and staff.

Summary of findings

Background to the service

Background to the service

Northamptonshire Healthcare NHS Foundation Trust (NHFT) integrated both physical and mental health community services in July 2011 as a way of improving and addressing the health and wellbeing of people who use the service in a holistic way.

Northamptonshire is the second fastest growing county in England. The Trust therefore serves a growing, socially diverse population of more than 700,000 people living in the districts and boroughs of Corby, Daventry, East Northamptonshire, Kettering, Northampton, South Northamptonshire and Wellingborough.

NHFT delivers many of the NHS services in the community for people over the age of 18. Their comprehensive range of services includes, podiatry, physiotherapy and district nursing services. These services are delivered to best meet the needs of people who use the service, whether in the patient's own home, through GP practices or in a residential or hospital environment.

The trust has over 4,400 staff that are committed to delivering care as close to home as possible for people who use the service and their relatives and/or carers. Where possible and appropriate to do so, they support people in their own homes. Staff also support people in their workplace as well as residential and/or care homes.

Our inspection team

The team who inspected this service were three CQC inspectors, three specialist advisors with specialist knowledge of community services and an expert by experience who had knowledge and had used the service.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive community health inspection programme

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients.

During the inspection, the inspection team visited seven patients in their homes and observed how staff were caring for people who use the service. This was with the permission of the person who uses the service. We spoke with 16 patients and four family members.

Summary of findings

We spoke with the service managers for each service, 30 other staff members; including doctors, nurses and therapists.

We attended a multi-disciplinary team meeting and observed three handovers.

We also looked at 16 treatment records of patients and reviewed a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider say

We spoke with 16 people who use the service and four relatives/carers and received good feedback from people we spoke with. People were positive about the support provided and used the word "excellent" to describe the nursing care provided. One patient said they were, "very caring". Another patient said the district nursing team was "excellent and attended to their needs."

Someone who was having regular wound dressing treatment said, "Staff are very professional" and, "They are always washing their hands." One relative said they looked forward to their visits as it alleviated the stress.

We spoke with a carer who was very positive about their experience and the care their relative had received. They told us that they found staff to be very caring and supportive, and had direct recent knowledge of using services.

Good practice

The Interim Community Service Manager had introduced a "Right First Time" initiative. This had been rolled out to the four community teams in the north of the trust to review areas of concern and look at ways to prevent serious incidents.

District nurses had demonstrated innovative practiced by introducing alternative wound dressing. Staff said the dressing could be cleaned between use and maintained good pressure area care.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should review the comprehensive discharge system between the acute services and the community services to identify areas of unsafe practice.
- The trust should ensure that local incidents are fed back to staff so that any trends or outcomes are identified and cascaded to staff.
- The trust should ensure that staff are aware of the safety thermometer and how it is used to measure harm.
- The trust should review the paper and electronic records to ensure that the recordings are accurate and do not contain variances and discrepancies.

Northamptonshire Healthcare NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

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

Requires Improvement

Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

We rated safe as requires improvement because:

The medical staffing levels in podiatry was adequate and there was good emergency cover but there was a shortage of community nursing staff and therapists with a high number of vacancies. Staff told us that they were worried about understaffing and the appropriate induction given to the agency staff used.

The service used both paper and electronic records. Staff completed electronic records on their return to their base due to connectivity issues. There meant there could be a risk of discrepancies between the paper and electronic records which could place people at risk of unsafe treatment and care.

Staff, where applicable, managed medicines well in the community. The environments were clean and staff followed the trust policy on infection control. However, we observed paint peeling off pipes and damaged walls at the Highfield clinic.

There was access to appropriate equipment to provide safe care and treatment. There were arrangements for the cleaning and sterilisation of instruments. The podiatry service did not have a system in place to identify instruments used which meant that it was difficult to track if concerns were subsequently identified.

Staff told us they were encouraged to report any incidents but said they did not receive feedback on localised incidents. Staff however said there was consistent feedback and learning from trust wide serious incidents at weekly meetings. The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls. Records

showed that incidents of these were high and the service was taking action to reduce theses. Patients were appropriately escalated if their condition deteriorated. Handovers were well structured within the community services visited. Staff had been trained and knew how to make safeguarding alerts.

Incident reporting, learning and improvement

In the last year there had been no "Never Events" within this service. A "Never Event" is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented. Between November 2013 and October 2014, community health services for adults reported 126 serious incidents through the National Reporting and Learning System (NRLS). For example, almost half (60) of the serious incidents reported were pressure ulcers.

Staff knew how to report any incidents on the trust's electronic reporting system and described a range of what they would report. Examples included poor care of patients, unsafe staffing levels and medicine errors. Senior staff were aware of incidents and said these had been discussed during regular team meetings. Most staff told us that they received feedback about the outcome of serious incidents that had happened but there was no mechanism in place for analysing local incidents so that trends could be investigated with outcomes learnt.

The unplanned care service had recently started "cohort" peer learning sessions for staff. These sessions included discussions of incident reporting and the actions arising from these. We saw actions identified from incident reviews had been effectively followed up. Following an incident in the podiatry services where a swab had gone missing, the process for checking swabs was changed. We saw that the revised process was in use and staff told us it was working well.

The community nursing teams used the NHS safety thermometer. This is a tool used at the point of care to measure harm and the proportion of patients that are harm-free. The safety thermometer looked at the incidence of pressure ulcers, falls and urinary tract infections. Analysis of the results was displayed for teams to see and discuss at team meetings. However, some community staff at the Castle Unit and Denton surgery said they were unaware of the "safety thermometer."

Staff had responded to an increase in falls by improving the monitoring of patients. Staff told us of their awareness of a higher risk of patients having slips, trips or falls. We saw completed risk assessments which had identified the risk.

Duty of Candour

Managers were aware of the duty of candour regulations and told us they were cascading this information to staff during team meetings. Staff said they were aware of the trust's openness and transparency when things went wrong. The manager informed us they had not yet had to implement the duty of candour regulations with regard to any incidents.

Safeguarding

Staff were able to demonstrate how they would report safeguarding concerns. One district nurse told us they had called the local authority safeguarding team as they had concerns about a patient they were visiting. Staff said the trust's electronic system had an icon which ensured the reported incident was allocated to the specific area which included safeguarding. All safeguarding concerns were reviewed by the senior management.

We reviewed the training records provided. The records showed that staff had completed their safeguarding vulnerable adults training. Also included were staff's refresher training due dates. Within the staff office at Brackley Health Centre was a poster telling staff what they should do if they suspected abuse. The Brackley team also had a resource folder which contained a flow chart for the reporting of abuse. Staff at Highfield clinic said they had been provided with credit card size information cards with details of whom to contact in the event of a safeguarding concern being identified.

A Multi-Agency Risk Assessment Conference (MARAC) meeting took place each month. MARAC is part of a co-ordinated community response to domestic abuse. Staff said the meetings made them "feel very safe and generates a lot of follow up work and liaison". Staff said these meetings were well attended by up to 25 agencies including adult mental health teams.

Medicines management

We found no issues or concerns with the administration of medicines. We saw that medicines administration was discussed at community nursing team handovers to ensure that patients received their medicines safety and at an

appropriate time. Staff were able to outline the reasons for varying doses of medicines which ensured that patient's safety was maintained. Staff prompted people to access their medicines. Senior staff told us staff did not administer medicines but encouraged and prompted people to access their medicines using a Monitored Dosage System (MDS). The MDS is a multi-dose reusable storage system designed to simplify the administration of medicines.

National Institute for Health and Care Excellence (NICE) 2010 guidance was followed when prescribing medication for individual patients. We observed the giving of insulin which was in line with the NICE guidelines on insulin used in type one diabetes. We saw the safe disposal of sharps using the sharps bin.

Staff at the Brackley Health Centre said they had issues accessing medicines and other items at the weekend. For example, if a patient required emergency catheterisation or urgent treatment for constipation. They said these items had to be prescribed which caused delays.

People were able to access the acupuncture service for pain relief. The trust had a checklist and consent form which was completed prior to treatment. We saw that acupuncture needles and sharps boxes were stored in locked cupboards when not in use.

Extended Scope Practitioners (ESP) carried out steroid joint injections and lignocaine injections. These were stored in the medicine cabinet in the ESP's room.

Safety of equipment.

There was sufficient equipment to maintain safe and effective care. Staff told us they made a request to the local equipment supply company which responded quickly and efficiently to their request with no delays identified. Equipment used in podiatry clinics was clean. We saw sterilised instruments were checked and monitored in accordance with local and national guidance.

We saw treatment being carried out in single rooms which were well equipped with couches and hand washing facilities. We saw a well-equipped gymnasium for group sessions at the Highfield clinic which had been maintained effectively.

Records and management

We looked at the electronic records of 16 patients attending physiotherapy, podiatry and dietetic clinics. The records showed that information about the patient included their medical history and allergies. We saw the records were updated immediately after the patient's consultation with the therapist.

The community nursing teams used a dual system of both electronic and paper records. Staff updated patients' home records at the end of their visit but updated the electronic records either on their laptop computer or on their return to their office base. There was a risk that information would not be accurately duplicated in both versions of the records. Senior staff told us they were aware of the concerns and were looking at ways of auditing the variances between the paper and electronic records. This meant there was a risk of discrepancies being recorded in people's records which could place people at risk of inappropriate treatment and care.

There were quarterly audits of records. Results of the audits were discussed at team meetings and action taken to improve. One community team had devised their own prompt sheet to ensure all patient assessments were completed. The records audits showed improved results since using this prompt.

Staff told us that patients' amended care plans had to be completely re-written due to the trust's electronic system's inability to accept amended changes. Staff said they found this process to be very time consuming.

Staff at the Castle Unit covered several sites. They said they encouraged patients to attend the one location but occasionally records had to be transported to different locations. Staff said they transported records in accordance with the trust's policy in a locked case in a locked car boot.

Cleanliness, infection control and hygiene

We saw care environments were generally clean and well maintained with the exception of the Highfield clinic where we observed paint peeling off pipes and damaged walls. Staff told us they had reported damp in the building to the maintenance department but had been told that refurbishment was difficult due to asbestos being reported in the building. The trust subsequently told us that the Highfield building did not contain any asbestos and the only two reports relating to damp were made in 2012 and resolved within that year.

Staff followed the trust's infection control policy. Staff were "bare below the elbow" and we observed staff using

appropriate hand washing techniques. Staff had access to personal protective equipment (PPE) which included aprons and gloves. When visiting patients' homes staff carried suitable supplies which included hand gel and anti-bacterial wipes.

We saw the decontamination of equipment had been on the risk register for three years within the podiatry services. There were arrangements for the cleaning and sterilisation of podiatry instruments. The service manager for podiatry told us that there were plans to use a central decontamination and sterilising service provided by local NHS hospitals. The plans included the use of disposable, single use instruments, particularly in outlying clinics. The trust had agreed to the business plan and equipment was due to be purchased before the end of March 2015.

The podiatry service did not have a system in place to identify the patient on whom an instrument had been used. This meant that if a patient developed a problem it would not be possible to track the process followed for the instruments used on that patient.

Mandatory training

The training records showed that most staff had completed their mandatory training. Any outstanding training had been identified and updated electronically to staff with due dates. Completion of mandatory training was discussed at team meetings and one to one supervision.

Assessing and responding to patient risk

Patients had individual risk assessments for example, the risk of developing pressure ulcers or falls.

Staff obtained written consent prior to a risk assessment being completed. Risk assessments had been regularly reviewed and updated.

We saw that appropriate risk to individuals had been identified for example the referral of a patient to the dietician following a significant weight loss. Patients referred to the podiatry services were assessed according to their needs. Those at higher risk of foot ulcers or those with medical conditions affecting sensation in their feet were seen more urgently.

Staffing levels and caseload

We were told the trust had revised their method of recruiting staff to community teams by introducing a rolling programme. This meant that more staff than are actually needed were recruited to allow for induction and handover. New staff are then placed where there is a vacancy. Some managers thought this was a good way to recruit whilst others had reservations as they believed the new member of staff might not always be suitable within an established team.

The staff survey for 2014 identified that 34% of staff felt pressurised to return to work when feeling unwell. This had improved from the 2013 result of 39%. One service manager said that sickness levels had been high but had improved due to the recruitment of new staff. A health professional at Battle house said they struggled to cover annual leave and sickness as they were not funded for agency or bank staff. The health professional said that they currently had unpaid trainee surgeons on work experience to make up their numbers.

Evidence was seen that additional staff were used when the needs of patients required this. We found that where gaps had been identified within the duty rotas this was being covered by the use of agency staff. This provided continuity to both patients and the staff team the community services used the same agency nurses. We reviewed the current and previous staff rotas and these showed us that there were enough staff on duty to meet the needs of the people in this service.

The managers told us they reviewed staff's caseloads daily, taking into consideration patients' needs and the skill mix of the team. Most staff told us their average caseloads was 19 which they felt were manageable. Some staff said there were occasions when their caseloads increased to 25 which stretched their capacity to support patients. Staff confirmed their caseloads were regularly reviewed within the staff team and at supervision.

The podiatry surgical service at Danetre hospital did not have access to an anaesthetist and we were told that if one was required they would "blue light" an anaesthetist across. This meant there could be a risk to the patients care and welfare. the trust told us that the service did not have an anaesthetist present because of surgical procedures under local anaesthetics and if there was a clinical emergency, this would be dealt with appropriately and emergency services accessed.

Managing anticipated risks

Community nursing teams had contingency plans for adverse weather conditions. This included the availability of suitable vehicles for driving in for example, snowy conditions.

Each location had a local risk register. For example, the services visited identified recruitment as an area of concern. The risk register identified the mitigation, the action and areas they were unable to address.

Staff were able to describe their action should a patient not answer the door. They gave a good account of the actions they would take. However, we did not find written protocol for staff to follow to support their actions.

We reviewed the lone working procedures which we saw was adapted by individual community nursing teams. The specific lone working arrangement for each team was not always available as written guidance for staff. Staff were able to tell us how the arrangements worked for their team. This included reporting by phone or text message when they arrived at and left a patient's home when working out of hours. We saw the lone working arrangements in practice for the unplanned service. Staff telephone into the base office after every visit. Staff in the base office used the electronic system to check the whereabouts of staff and would contact them if they had not telephoned in after a visit.

Requires Improvement

Are Community health services for adults effective?

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

We rated effective as required improvement because:

There were long waiting times of up to eight months for patients referred for physiotherapy classed as non-urgent. The target from the clinical commissioning group was for non-urgent patients to receive appointments within two weeks of referral. Patients at the surgical podiatry service at Battle House had an average wait of between six to nine months from assessment to referral to surgery time.

The service demonstrated that care was provided in accordance with evidence-based national guidelines. National guidelines and pathways were used extensively, so that best practice was used to manage patients care. Policies and procedures were accessible for staff and staff were able to guide us to the relevant information.

Care was monitored to demonstrate compliance with standards and there were good outcomes for patients. Patients pain was appropriately managed as was the nutrition and hydration of patients. Multidisciplinary working was evident to co-ordinate patient care.

Overall, staff had access to training and had received regular supervision and annual appraisal. Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and their assessments of mental capacity were detailed.

Clinical staff made a comprehensive assessment of people who were referred. This included a good assessment of people's physical health needs. The trust used both an electronic system and paper copies for recording and storing information about the care of patients.

Evidence based care and treatment

We found that care was delivered in a holistic manner which promoted not only patient's physical health needs but also addressed their psychological needs.

Staff were able to show how they provided care and treatment to both patients and carers in line with the National Institute for Health and Care Excellence (NICE) guidelines. For examples, the records identified the involvement of patients in partnership with their health and social care professionals. The records read showed staff adhered to the NICE guidelines April 2014 for the prevention of pressure ulcers. We saw pressure prevention equipment in place for example mattresses and cushions. The care plan wound assessment and treatment chart followed NICE guidelines which included wound type, size and appearance. The physiotherapy service offered acupuncture as an alternative therapy to patients with back pain. This treatment followed NICE guidelines.

The trust had phased out the Graseby syringe driver and introduced the Mckinley syringe driver in response to safety guidance from the National Patient Safety Agency (NPSA). This meant that any potential harm to patients had been reduced.

The therapists used the Malnutrition Universal Screening Tool (MUST) to raise awareness of a person's risk of malnutrition. This tool was used during the initial assessment of a person entering the service.

Approach to monitoring quality and people's outcomes

Patients questionnaires were used to assess and monitor the quality of the service and the outcomes of the treatment provided. The questionnaires could be completed online or on paper and handed back to staff in an envelope. The questionnaire covered for example; pain and discomfort, mobility and anxiety and depression. The questionnaires were analysed by an independent organisation. Staff said they were given feedback from the analysis of the questionnaire during team meetings.

The interim operations manager for adult community services attended monthly performance and quality meetings to discuss all specialities which included quality performance targets. The physiotherapists told us they were in the process of monitoring the improvement and outcomes of patients attending group exercise classes after surgery for hip and knee replacements. The falls team were meeting their key performance indicator regarding waiting times. They were seeing people within three to four weeks

against the trust's target of six weeks. The brain injury team said they reviewed patient's goals quarterly to ensure their goals were true and that their expectations of the goals were realistic

We attended a pro-active care meeting held weekly between staff of the Queen Victoria Memorial (QVM) hospital and the Pines surgery. The meeting was attended by the district nurses, GP and the practice manager for the QVM hospital. The meeting discussed patients who were frequent admissions and the care and treatment required to keep them at home. This included reference to other services for example, hospice at home and the Asperger's team.

We saw assessments of people's needs were comprehensive and included the assessment of pain. We found that the outcome of treatment was being monitored and reviewed at management meetings. We saw assessment tool audits for example, the determining of patient's risk of inadequate nutrition. Staff told us the results of these audits were shared with them at team meetings and one to one supervision sessions.

The podiatry service at Battle House conformed to the Podiatric Audit of Surgical and Clinical Outcome Measures. We saw the last audit (July 2014) which did not highlight any issues or concerns. For example, the invasive medications report and the invasive anaesthesia report showed a score of 100% compliant. The patient satisfaction questionnaire for the podiatry service at Battle House showed that 96% of patients said they would have surgery again and 97% had been told of the risks associated with surgery.

Competent staff

Managers in the unplanned care service had developed "cohort" peer learning sessions for staff. This was a protected day which included training, talks from visiting speakers and reflective sharing and learning on practice as a group. Managers told us this was a useful way of delivering training to ensure competency and consistency of practice amongst staff.

All staff had annual syringe driver updates and competency checks. Physiotherapists who provided acupuncture had received appropriate, accredited training to ensure their competency. Some staff within the physiotherapy department were extended scope practitioners. This meant they had additional skills, experience and training. For example, they could provide treatment such as injections into joints which would normally be given by a doctor. They were also able to provide advice and support to other physiotherapists. One staff practitioner told us they had been offered the opportunity to take a physiotherapy degree training course. This is a government initiative supported by the trust.

The staff survey for 2014 identified that 87% of staff had been appraised in the last 12 months. Most staff told us they received regular one to one supervision and annual appraisals which incorporated learning and development needs. Some staff within the Northamptonshire West team said their planned supervision sessions had been cancelled due to pressures of work. They did however recognise they could access adhoc supervision if necessary. Some staff said they regarded the daily handover as clinical supervision.

Staff within the Northamptonshire east and south teams said that new staffs' corporate induction had been reduced from five days to two. They said this resulted in new staff working with the team with limited training. Staff said they had to take time out of their schedule to support and train new members of staff.

Multi-disciplinary working and coordination of care pathways

Staff in community teams told us that multi-disciplinary working was good. Staff felt able to consult with colleagues and there was a good rapport with ward staff in bases at community hospitals. There was good professional input from specialists and medical staff where present. We attended a multi-disciplinary meeting and observed that each team member's role was respected in terms of information sharing about people's care. Plans for progress and the resolution of issues for people were decided at the meeting. Staff were clear about the next steps for people who use the service.

Specialist nurses were available to provide consultation when required. Staff said they worked within a supportive team. District nurses described a close working relationship with the tissue viability nurse and community occupational therapists.

Staff's caseloads were reviewed which included the time frame for discharge from the service. It was evident that

Are Community health services for adults effective?

discharge was subject to a package of care being in place. The availability of social care response was identified as an area of concern which could impact on the team's ability to timely discharge people into the community.

Community nursing teams and the intermediate care team worked together to provide care and treatment for patients in their own home. Some staff said the working arrangement could be improved to give patients a more effective and efficient service. There were issues with nurses from each team visiting the same patient to deliver care that could be provided by one nurse. Staff said that this could cause anxiety and confusion to patients.

Referral, transfer, discharge and transition

There were concerns with the discharge system from local acute hospitals with the community teams, on occasions, not being informed when patients needed the support of district nurses. The loss of the community liaison service from the acute hospital had given rise to more unsafe discharges. During our visit the district nurses recorded an incident whereby a patient, who was insulin dependent, and had to have insulin administered by the district nurses had been discharged without their knowledge. The information provided on discharge was not always accurate regarding the patient's condition and needs. District nurses said they followed up hospital discharge problems by reporting them as incidents and speaking to ward staff.

The provision of podiatry services for people in Northamptonshire had changed in April 2014. This meant that people who had low risk foot health needs such as verrucae, corns and nail surgery and who did not have underlying health issues would no longer be seen by the podiatry service in Northampton. Patients using the podiatry service could refer themselves or be referred by their GP or hospital consultant. All referrals seen by a podiatrist were assessed according to risk. For example, urgent high risk patients were seen within 48 hours whilst less urgent patients were seen within two to three weeks. The completed referral form was assessed by the podiatrist who decided if podiatry care would be provided.

Patients who did not attend their appointments within podiatry and dietetics were offered another appointment. They were discharged if they did not attend again without a valid reason.

The physiotherapy services had been reconfigured across the trust. Staff told us the service was initially configured to take 24,000 referrals per year. However, the referral had reached 36,000 and this had been identified on the risk register. Management told us meetings were being held with commissioners to increase the number of physiotherapy posts. The physiotherapy service received referrals from various sources for example, direct from the public or the GP services. Physiotherapy patients were discharged if they did not attend without giving a reason. We saw this was made clear though information displayed in the clinics.

There were long waiting times of up to eight months for patients referred for physiotherapy classed as non-urgent. The target from the clinical commissioning group was for non-urgent patients to receive appointments within two weeks of referral. The trust held an "Any Qualified Provider" (AQP) contract to provide support to the physiotherapy services for patients with shoulder, knee and back problems. These referrals were seen within two weeks in accordance with the contract.

Patients at the surgical podiatry service at Battle House had an average wait of between six to nine months from assessment to referral to surgery time. This was confirmed in the records read. Staff at the surgical podiatry service said they triaged podiatry patients and received about 10% of inappropriate referrals from GP's. Staff said they would always see the inappropriately referred patient before sending back to their GP.

Patients were referred to the dietetic service by their GP, hospital consultant or community nurses. Non-urgent patients were seen within 13 weeks although patients referred for support with weight management waited longer.

At weekends some community nurses hold the emergency "111" phone which is used to refer patients to the district nursing service. The nurses at the Brackley Health Centre said they were also expected to carry out visits. They said they had raised concerns regarding the effectiveness of this, as occasionally, they received calls when attending to a patient or due to poor network coverage they did not receive the call. Nurses said they found the delays in network coverage to be very time consuming. Nurses from the eastern and southern teams who held the "111" phone were based at the out of hours service. They told us they did not carry out visits to patients' homes.

Requires Improvement

Are Community health services for adults effective?

There were processes in place for referring patients to the evening service. Referrals received during the day were triaged for their urgency. The district nurses did not have a waiting list for visiting patients and said they worked until the visits had been completed.

The speech and language therapist said there had been in increase in dysphagia (swallowing problems) referrals especially amongst patients with a diagnosis of dementia or motor neuron disease.

Availability of information

Community nurses were able to access patient's paper records when visiting their homes. Staff had access to patients' electronic records through the use of laptop computers. This meant they had access when not at their office base. Community nurses said there were occasions when the laptops could not be accessed due to connectivity issues which caused problems in accessing people's records.

Information on the trust services were also available on their website.

Consent

Patient's records included their consent to care and treatment and the sharing of information with others for example, their GP. Most staff demonstrated awareness of the Mental Capacity Act (MCA) 2005. They were able to describe how they would support patients to make decisions for themselves wherever possible and the procedures should a patient lack capacity to make decisions. Staff said they had received training and guidance regarding the MCA which was confirmed in the training records viewed.

Good

Are Community health services for adults caring?

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

We rated caring as good because:

Staff were caring and compassionate to patient's needs and treated patients with dignity and respect. There were concerns with the vertical blinds covering windows at the Highfield clinic as they were not hanging and closing correctly. This meant there was a risk of patient's dignity and respect being compromised.

Patients told us that staff treated them in a caring way, and were flexible in their support to enable patients to access services. Patients and families said they were kept informed and felt involved in the treatment received.

We saw staff were kind and respectful to people and recognised their individual needs. They actively involved people in developing and reviewing their care plan and individual goals.

People said they could access an advocate if they needed one.

Dignity, respect and compassionate care

We saw good positive examples of staff and people's interaction during our visit into the community. We saw that staff treated patients with kindness and respect. Staff explained to us how they delivered care to the different people who use the service. This demonstrated that they had a good understanding of these different needs.

Physiotherapy at some clinics was provided in curtained off cubicles. This offered some privacy but discussions between patient and therapists could still be overheard by other patients. We observed that the vertical blinds at the Highfield clinic were not hanging correctly and did not completely close. As the department was on the ground floor, this meant that patients dignity might be compromised as people could see in.

Patients were positive about the community nursing team. They said staff respected their privacy and dignity and treated them with respect. One patient said "They never rush me. They're so kind. They listen to me."

Patient understanding and involvement

Staff took time to ensure that patients understood their care and treatment and were involved in making decisions. This meant that patients were able to make choices about their health and form decisions about their lifestyle.

Emotional support

During our visits to patient's homes we observed the community nurses providing emotional support to a person who was distressed. They spoke calmly and with respect whilst respecting the person's dignity.

Promotion of self-care

Staff supported patients to manage their own health care and maximise their independence. For example, we observed a health care assistant talking to a patient and giving practical advice to increase their mobility. District nurses showed patients how to give their own injections of a drug used to prevent blood clots. Staff in the diabetic and high risk foot clinic gave verbal and written advice to patients about how to prevent problems.

Good

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

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

Summary

We rated responsive as good because:

The services were aware of the diverse needs of the people who use the service and provided a range of support as required. The services were able to provide a range of different treatments and care. People could access a range of therapeutic interventions. Information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used.

National waiting time targets for Referral To Treatment (RTT) for 18 weeks for those services applicable to the trust were being met. There were longer waiting times for the dietetic service.

There was support for people with a learning disability and reasonable adjustments were made to the service for example, patients were given longer appointment times to take into account any anxiety. Staff were able to refer any issues or concerns to the learning disability lead.

Patients reported that they were satisfied with how to make a complaint and how they were dealt with.

Planning and delivering services which meet people's needs

The services were able to provide a range of different treatments and care. People could access a range of therapeutic interventions. The trust had produced information literature. This could be requested, when required, in a different language or format. The trust had access to interpreting and translation services from which they could arrange both face to face and instant telephone interpreting, document translation and British sign language services.

Written information was available to patients about their care and treatment and medical conditions. These could be requested in a different language when required. Information leaflets depicting exercises were in picture form which enabled the patient to follow the exercises given.

The dietetics service provided a weight management clinic for patients who needed support to achieve and maintain a healthy weight. Management said the demand for the service had increased and exceeded the current capacity but a business case to extend the service had been put forward to the clinical commissioning group. Patients who attended a focus group told us that the Dose Adjustment for Normal Eating course was excellent and "revolutionised the way that diabetes is managed." However, they said the GP and the diabetic service were unaware of the course which was accessed by self-referral only. We were informed there was an 18 month waiting list for this service. The trust told us that all GPs had been made aware of the course and details of referral are included in service information for the Diabetes MDT.

We found that policies and protocols had been updated to improve the involvement of families/carers (where appropriate), in decisions about care.

New patients attending podiatry, physiotherapy and dietetic clinics were given longer appointments. This allowed extra time for assessment of the patient's condition and needs. Staff told us that they had introduced a system of texting reminders to patients. This had led to a reduction in missed appointments by patients.

The service manager for the physiotherapy department said they were considering options to reduce the waiting lists. Areas identified included the telephone triaging of patients, additional assessment clinics for new patients and the running of group classes for patients requiring similar treatment.

Staff at the Brackley Heath centre said they had access to two syringe drivers but had on occasions borrowed additional syringe drivers from other surgeries. This may mean delays in delivering treatment to patients in the community.

There was a hyperbaric oxygen chamber in Bedford which was available for patients suffering from multiple sclerosis. Hyperbaric oxygen therapy is a treatment where a patient breathes in pure oxygen while under increased air pressure. Staff said they would openly discuss the positive and negative benefits of the oxygen chamber but would not make any recommendations as it was down to patient's choice.

Good

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

Equality and diversity

The training records identified that staff had completed their training in equality and diversity. Staff were able to say how they would demonstrate their understanding of equality and diversity by ensuring that patients were treated fairly and specific to their needs. This included areas of race, gender, disability and , religion or belief.

Meeting the needs of people in vulnerable services

The community nursing teams were liaising with the service for people with a learning disability to ensure they had access to community nurses when needed. Staff said there had, on occasions, been issues where a person with a learning disability had been given instructions to contact the district nurse at discharge. They said instruction had not been carried out due to the patients being unable to do this for themselves and/or their carer being unaware of the instructions. This meant there was a risk of patients not receiving the services of a district nurse when required.

Access to the right care at the right time

Most staff in community teams said access to standard pressure relieving cushions and mattresses was not a problem and when required, they could access bariatric equipment.

The service had access to the trust's speech and language therapists for advice and guidance to assist patients with communication difficulties. The records showed the waiting list for therapist was 12 weeks although patients with swallowing problems were seen within four to five weeks. This was confirmed by therapists spoken with.

A patient told us they had phoned the district nurse because of deterioration in their leg ulcers. The district nurse visited later the same day and the patient said they felt "reassured that help was available so quickly." Another patient told us they had a problem with their foot on Christmas Eve and were pleased when they were able to get an urgent appointment that day. The clinician said that they left spaces in each clinic for urgent appointments

Patients attending the diabetic and high risk foot clinic were seen regularly, usually every three months, for a review of their condition and treatment. Patients were also able to phone the clinic with any problems between appointments and where required urgent appointments would be arranged. Home visits were carried out occasionally for diabetic and high risk foot clinic patients if they were housebound.

There were long waiting times of up to eight months for patients referred for physiotherapy classed as non-urgent which did not meet the two week target set by the clinical commissioning group. There was a waiting list of 18 months for the Dose Adjustment for Normal Eating diabetic course and patients at the surgical podiatry service had an average wait of six to nine months from assessment to referral to surgery time. This meant

Patients who attended a focus group told us that the Dose Adjustment for Normal Eating course was excellent and "revolutionised the way that diabetes is managed." However, they said the GP and the diabetic service were unaware of the course which was accessed by self-referral only. We were informed there was an 18 month waiting list for this service. This meant that patients were unable to access care for certain conditions within the required time.

National waiting time targets for Referral To Treatment (RTT) for 18 weeks for those services applicable to the trust were being met.

Complaints handling (for this service) and learning from feedback

Information was displayed for patients to report any 'concerns, complaints, compliments' and there were systems for them to be investigated and complainants to be given a response**.** Staff supported people and carers to make complaints as required. Staff said they would refer complaints to the Patient Advice and Liaison Service (PALS) if they were unable to resolve the issue locally. Feedback and lessons learnt from complaints were discussed at team meetings.

People were able to raise concerns and comments during their assessment meeting with the doctor and specialist staff. Patients had access to the "Total Voice" advocacy services. The advocacy service provided independent advocacy for people aged over 18.

Good

Are Community health services for adults well-led?

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

Summary

We rated well-led as good because:

There was positive awareness among staff of the values and expectations for patient care across the trust. There were monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.

The service held regular group engagement session for all staff which included training updates. Staff were able to raise any concerns or share an experience within their teams. Staff said they felt there was effective team working across professional groups in the community service. Some staff said they felt pressurised when patient referrals fluctuated. Senior managers said they were aware of the issues, and were monitoring the additional pressure at team meetings and supervision.

Patients were engaged through feedback. These showed us that patients were given advice on the treatment given.

Innovation was encouraged from all staff members across all disciplines. Staff said they were encouraged to develop new ideas and to make continuous improvement in the service provided.

Service vision and strategy

The managers and staff said they were clear about the vision for the service and how this would be achieved. The trust had adopted the acronym 'PRIDE' which summarised their core values. These included; putting patients first, respecting each person as an individual, improving patients lives, dedication to the quality of care provided and everyone being counted as equal. Staff said they were unsure what the acronyms PRIDE actually stood for, but gave a good account of the principles behind them. We saw posters on office walls describing the PRIDE acronym.

Governance, risk management and quality measurement

There was a risk register for the adult community service and also local risk registers for the community nursing teams. Managers told us they updated the risk registers and escalated their concerns when necessary.

Local governance meetings took place which cascaded into divisional meetings. The minutes showed us that these were comprehensive and any actions arising had been addressed. These were placed in the team folder for staff to access.

Staff confirmed that they received e-mails from the trust giving updates on corporate developments. Team brief documents were circulated for staff to read.

There were staff resources to deliver and monitor staff training on and off site and via e-learning. Staff said they received annual appraisals.

Leadership of this service

Regular team meetings took place and staff told us that they felt supported by colleagues and managers.

Daily clinical leads meetings were held in the morning to review any issues.

Some staff said that there had been many management changes over the past few years. Examples included senior staff having to re-apply for their roles. They viewed this as disruptive to team consolidation and led to instability. One district nurse said their line manager "Leads from the front. She's very hands on and very supportive."

Most staff were positive regarding the quality of leadership from their line managers, senior managers and the chief executive. There were some concerns from the Wellingborough team regarding the management structure which they felt was untenable. Some staff at the Denton surgery said that occasionally teams were unwilling to be flexible in helping other teams especially if the area was under pressure.

Good

Are Community health services for adults well-led?

Staff said that the chief executive officer (CEO) was very responsive. A service manager commented that the CEO "Has really settled us down. I have every confidence in them to carry on making improvements." In contrast staff felt the executive team were not visible to staff.

Whilst there were challenges with recruitment and retention of staff for the services evidence was seen that the provider was taking action to pro-actively recruit and retain staff. We saw that 82% of staff had received annual appraisals and regular supervision. The trust had a human resources department and referred staff to occupational health services where applicable.

Some staff told us their rostering system had recently changed and an e-rostering system introduced. They said it was causing unrest amongst of the team as established shift patterns had been changed and there seemed to be no recourse to accommodate individual needs such as child care arrangements.

Culture within this service

Staff shared their views about the service openly and constructively. They were caring and passionate about the service and the care they provided to people who use the service. Staff worked well together as a team. A health care assistant told us "I love it – every day is different. It's such a good team; I know I can ask for help anytime."

Fit and proper person requirement

The trust had an obligation to ensure that staff employed were fit for their role. We looked at three staff copy records during our visit. Senior management confirmed they reviewed the records provided by the human resources department to ensure that staff employed were of good character, were physically and mentally fit, and had the necessary qualifications, skills and experience for the role. We saw the records had the appropriate Disclosure and Barring Services (DBS) checks and references.

Public and staff engagement

Patient feedback was actively sought by staff using the "I want great care" questionnaire. The results and analysis were fed back to each team.

Staff in the community nursing teams told us about initiatives to involve and engage staff. This included regular e-mails from the chief executive to staff and open sessions with senior managers for staff to attend. Information was sent to staff regularly by e-mail and newsletter. Staff were encouraged to look at the staff intranet. The district nurses had a bi-monthly newsletter.

There was information about the services on the trust's website.

Innovation, improvement and sustainability

The community nursing team and the unplanned care service were being reorganised to improve patient experience and to provide a more effective and efficient way of working. The managers were committed and enthusiastic about the changes.

Periodic service reviews had taken place to monitor the quality of the service with actions identified as relevant. We saw examples of improvement to the service for example, mobile phones improving communication between staff and with patients and this reduced the "do not attend" figures.

The proposed introduction of new integrated technology communication equipment would support staff to access information and enable core office based staff to monitor staff's whereabouts and work demands.

The podiatric surgeon at Battle House said that they encouraged staff to be innovative. This had resulted in one of the team have an article printed on gestation and another on technique tips for bunion surgery.

The multiple sclerosis specialist nurses said they had been encouraged and had written a report on the integrated care pathway for multiple sclerosis which had been printed by the British Journal of Neuroscience Nursing.

The operations manager had introduced a "beat the cut" process. This was rolled out to the four community teams in the north of the trust. The aim of the scheme was to prevent serious incidents. Each team had been given an area to oversee for example, records and case load waiting times.

One patient said the district nurse had "gone the extra mile" by sourcing an alternative wound dressing. This was a silicone shaped pad which discreetly fitted under the patient's trousers. Staff said the dressing could be cleaned between use and maintained good pressure area care. They had arranged a meeting with the team on this product.

Good

Are Community health services for adults well-led?