

University Hospital of South Manchester NHS  
Foundation Trust

RM2

# Community health services for adults

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RM201	Withington Community Hospital		
	Brownley Green Health Centre		
	Burnage Health Centre		
	Northenden Health Centre		
1-58783963	Forum Health Centre		
RM2X3	Wythenshawe Offices		

This report describes our judgement of the quality of care provided within this core service by University Hospital South Manchester 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 University Hospital South Manchester NHS Foundation Trust and these are brought together to inform our overall judgement of University Hospital South Manchester NHS Foundation Trust.

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

The overall rating for adult community services was 'requires improvement' with some areas good.

The adult community services had no robust systems in place to monitor safety performance. There was a lack of fully completed risk assessments in patient records and we were not assured that patients were receiving harm free care.

The trust had an electronic system to record incidents and all staff we spoke with knew how to access the system. When serious incidents were reported, the trust performed a root cause analysis to determine if incidents were avoidable. We found, where incidents were found to be avoidable, learning and actions were not completed and we were not assured that the trust was learning from incidents. We found not all incidents were reported.

There had been recent changes following a consultation with staff that had resulted in the integration of community nursing services. This had resulted in a reduction in senior roles and experienced staff leaving the service. We were not assured that staff that had been redeployed into new roles had the competencies to fulfil their role and at the time of our inspection the trust had not performed a training needs analysis to understand the gaps: however, they informed us at the time of our inspection that they were planning to complete one.

There were high nursing vacancies at the time of our inspection and although there was a recruitment plan in place high vacancy levels were experienced prior to June 2015. This was having a negative impact on staff morale and the trust was not achieving the contracted contacts for the service.

Care and treatment did not always reflect current evidence-based guidance. Care assessments we reviewed were not fully completed and so did not consider the full range of people's needs. Outcomes of people's care and treatment was not monitored regularly within the nursing services: however, there was a monitoring process in

place in therapy services. There was a lack of consent to treatment documented in nursing records. We found clinical policies were not being adhered to and some were out of date.

There was a lack of robust systems in place in relation to lone working to keep staff safe in the integrated community nursing teams. We accessed the lone worker policy on the trust intranet which was out of date. Staff in therapy services knew where staff were and had a timely system to respond if staff were late arriving at their destination.

There was a governance structure in place within the community services which fed into the trust risk management committee. Risk issues and poor performance were not always dealt with in a timely manner. Risk registers were in place but we found that some risks identified by staff were not on the risk register.

Premises we visited at the time of our inspection were appropriate for the services being delivered. Cleanliness and hygiene was of a high standard throughout the clinics we visited and staff followed good practice guidance in relation to the control and prevention of infection.

There was timely access to services and people with the most urgent needs were prioritised. Improvements in service delivery had resulted in a significant reduction in waiting times for therapy services. There was a process for patients to make a complaint: however, staff informed us that most complaints were dealt with informally and resolved at service level. There was no process in place to monitor or record these informal complaints to enable learning from complaints.

The adult community service was delivered by caring, committed, and compassionate staff that treated people with dignity and respect. Staff actively involved patients and their carers in all aspects of their care.

Services were responsive to people in vulnerable situations and interpreting services were available as required.

# Summary of findings

## Background to the service

University Hospital of South Manchester NHS Foundation Trust provides a wide range of community based health services for adults, supporting health and wellbeing, minor ailments, and serious or long-term conditions. The services provided include: community nursing, podiatry, nutrition service, continence service, physiotherapy and occupational therapy services and tissue viability.

The community nursing services are newly integrated into four patches across the community to promote an integrated nursing care provision and include district nursing, active case management and rapid response with a single point of access for new and urgent referrals to the service. The community nursing service accounts for more than half of the adult community services workforce.

Therapy services are also integrated into one service to promote integrated therapy care provision and include physiotherapy, occupational therapy, early supported discharge and speech and language. The community nursing and community therapy services currently sit within the unscheduled care division within the trust. Services are provided across South Manchester in people's homes, residential and nursing homes, clinics and in community venues.

Specialist services were provided and included tissue viability, continence, and nutrition services. The specialist teams provided services in both the hospital and community settings.

As part of our inspection, we inspected services on 26, 27, 28 and 29 January 2016 across six different locations across South Manchester. The services we visited included:

- Integrated community nursing (including out of hours and treatment room clinics)
- Integrated community therapy
- Single point of access
- Tissue viability service
- Continence service
- Nutrition service

As part of our inspection we reviewed data provided by the trust, spoke with 56 members of staff, spoke with 10 patients and two carers, and viewed 16 patient records.

## Our inspection team

Our inspection team was led by:

**Chair: Jenny Leggott**

**Team Leader: Lorraine Bolam**, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a senior community nurse and an occupational therapist.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection of University Hospital South Manchester NHS Foundation Trust.

# Summary of findings

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 26, 27, 28, 29 January 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, 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.

## What people who use the provider say

We spoke with ten patients and two carers during the time of our inspection and they told us:

- "nurses do appear busy, would like them to stay longer"
- "cannot complain, all very pleasant and kind"

- "I don't know what I would do without them"
- "trust them with my life"
- "not seen a team leader"

## Areas for improvement

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

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

- The trust must ensure they have robust systems in place to monitor safety performance across all community services to ensure patients are receiving harm free care.
- The trust must make all reasonable efforts to recruit to staff vacancies within a timely manner.
- The trust must determine safe staffing against clinical caseloads and ensure safe staffing levels are in place.
- The trust must ensure all clinical policies are reviewed and in date.
- The trust must ensure staff are trained to operate any equipment that they use to carry out their role

- The trust must ensure staff have the essential qualifications to fulfil their role
- The trust must ensure that risk assessments are being performed as per trust policy and findings are documented in the patient record.

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

- Develop a process to report and monitor informal complaints to the services.
- Ensure services have effective systems in place to support lone working.
- Ensure that equipment is safely maintained.
- Ensure audits are in place and actions are taken to improve the documentation of patient risk assessments.
- Ensure consent to treatment is documented in all patient records.

# Summary of findings

- Ensure equality impact assessments are completed to determine impact on people who use services prior to changes to services.
- Consider options to improve recording of patient contact activity
- Ensure they have effective systems that accurately monitor patient outcomes which are reflective of the services they provide.
- Ensure wound care products are stored appropriately in the treatment room areas.

Improve the reporting of incidents and systems for learning to be shared from incidents.



## University Hospital of South Manchester NHS Foundation Trust

# Community health services for adults

### Detailed findings from this inspection

Requires improvement 

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We rated community adult services as 'requires improvement' for safe.

There was no robust system in place to monitor safety performance across all the services provided and we were not assured that patients were receiving harm free care.

We found patient records to be incomplete with a lack of comprehensive risk assessments which could result in patients' needs and risk factors not being identified. We found that when incidents were reported and a root cause analysis was performed, the lack of risk assessments and poor documentation had been identified as contributing to avoidable harm.

Not all incidents were being reported and there was a lack of shared learning from incidents. We found actions identified following review of incidents not being implemented.

We were not assured that staffing levels within the integrated community nursing service were safe and there were no caseload weighting or acuity tools used to determine safe staffing levels on a daily basis. There were high numbers of vacancies within the community nursing services which had existed prior to June 2015. All vacancies were placed on hold in June 2015 due to the integration of community nursing services. In November 2015 a recruitment plan was put in place. Control measures identified to manage the risk of low staffing levels were identified and included: prioritising of the workload, recruitment to posts, and monitoring of incidents. The action identified was a daily assessment of safe staffing levels and a formal escalation plan. At the time of our inspection the trust had no process in place to determine safe staffing levels despite the integration of the nursing services since September 2015.

The result of staffing pressures was having a negative impact on staff which included low staff morale, staff feeling under pressure and unable to take their breaks, and

## Are services safe?

staff were finding recording contact activity difficult. The community services activity report November 2015 had identified that community nursing were behind the planned activity of contacts by 51% which could be due to the staff not recording contacts due to work pressures. Staff safety with regards to lone working was being compromised. We found there was a lack of robust systems in place within the integrated community nursing teams to keep staff safe and no nominated person responsible. Two nursing teams we asked were unable to demonstrate how they knew all staff had been safe at the end of their previous shift.

We were not assured that there were robust systems in place across all the community nursing teams to ensure equipment was safely maintained as there were syringe driver pumps for administration of drugs that were out of date with their maintenance checks.

Patients were protected against healthcare associated infection and staff adhered to infection control policies.

The adult community services had met the trust target in relation to attendance at safeguarding training.

### Detailed findings

#### Safety performance

- The community adult services did not use the NHS safety thermometer to monitor their safety performance. The NHS safety thermometer is a national improvement tool for measuring, monitoring, and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms include: falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE).
- Pressure ulcer incidence was recorded via the trust's electronic incident reporting system and monthly performance and accountability meetings were held: however, we were not assured that other areas of harm including CAUTI, falls, and VTE, were being monitored and analysed and patients could be at risk of avoidable harm.

#### Incident reporting, learning and improvement

- Staff we spoke with were aware of the electronic reporting system and how to access and use it.

- We reviewed incident reporting for the period November 2014 to October 2015. There was a total of 646 community related incidents reported with 487 of these relating to community nursing. Of these 487 incidents, 334 were in relation to pressure ulcers.
- We were not assured that staff were aware of their responsibility to record all incidents. During conversations with staff they informed us of incidents that they had not reported on the electronic system. These incidents included: electronic referrals not being accessed at weekends and bank holidays, the single point of access (SPA) phone not being diverted, and nursing staff unable to attend treatment room sessions on time due to workload pressures. Between November 2014 and October 2015 community adults services had reported no never events. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There were three serious incidents requiring investigation reported within community adult's services between November 2014 to October 2015. The serious incidents were all in relation to pressure ulcers which following a root cause analysis (RCA), were all deemed to be avoidable. In June 2015 a lack of documentation to support pressure ulcer prevention, no documentation of any skin inspection, no referral to dietician and a delay in ordering a pressure relieving mattress following the first Waterlow assessment that identified the patient at risk were identified as causing harm. The second incident in July 2015 identified a delay in a feeding regime review for a patient receiving nutrition via a percutaneous endoscopic gastrostomy which resulted in the patient sitting for long periods. Communication with carers in relation to roles and responsibilities was also identified as a cause for delay in care. The third incident in August 2015 identified a lack of a mental health review and poor communication with carers causing a delay in care.
- We saw action plans from the RCAs to address the concerns identified. One was the review of documentation and for an audit during December 2015. We requested a copy of the audit from the trust however; the trust informed us they were unable to locate this audit.
- There was no documented evidence of duty of candour being recorded in the RCAs we reviewed. The aim of the

## Are services safe?

duty of candour regulation is to ensure trusts are open and transparent with people who use services, and inform them and apologise to them when things go wrong with their care and treatment. We asked staff nurses and therapy staff what they understood by the duty of candour and all were able to correctly describe it as being open and honest with patients when harm had occurred.

- Learning from incidents was inconsistent across the community adult services and we found a lack of evidence to support this was in place. The lack of learning from incidents had been raised as a challenge in the November 2015 minutes of the complex health and social care governance meeting however, no solutions were recorded.

### Safeguarding

- Staff understood and were able to explain the process for reporting safeguarding concerns. We saw seven safeguarding concerns recorded on the electronic system from 1 September 2015 to 31 October 2015.
- Staff reported they had completed training for safeguarding for adults and children. We reviewed data for community adult services and found out of a total of 165 staff, only one staff member was outstanding safeguarding adults level one at December 2015. For the same period, 86.07% had completed safeguarding adults level two, 98.79% had completed safeguarding children level one, and 89.7% had completed safeguarding children level two. The community adult services had met the trust target for 85% of staff to complete training.
- Staff reported good timely responses from the safeguarding team and would ring the team if they needed advice. The tissue viability team gave an example of learning from a safeguarding incident which resulted in them maintaining their own copy of entries they made into patients' nursing home records.
- Patients with grade three and above pressure ulcers were referred to the trusts and local council's safeguarding team.
- We saw the safeguarding team contact details on display in one of the integrated community nursing team's office that we visited.

### Medicines

- Community nurses administered controlled drugs via sub-cutaneous injection and via the T34 syringe driver pumps in line with the trust policy and National Institute for Health and Care Excellence (NICE).
- On most occasions controlled drugs were collected from the pharmacy by carers or the patient's family or were delivered to the patients' home by a pharmacy. Staff told us that in extreme cases when there was no one able to support the patient with this they would collect and deliver the drugs.
- Controlled drugs were kept in the patient's own home and stock checks and administration records were recorded in the patient held record.
- When drugs were no longer required, family and carers were asked to return them to the pharmacy. However, if the nurse had identified any issues of concern, the nurses would destroy the drugs and use a controlled drug destruction jar (doop kit) which allows rapid and successful denaturing of pharmaceutical products.
- Staff reported having a trust wide wound care formulary to work from for providing wound care to promote a standardised approach. Dressings were ordered using an electronic ordering system. Staff that were able to prescribe as non-medical prescribers informed us that this had resulted in them not generating any prescriptions for dressings. Prescription pads were stored in locked cabinets when not in use as per trust policy. The dressings were delivered and stored at team bases. However, during our inspection we observed a number of dressings being stored on the windowsill in the Forum Health Centre treatment room which could potentially present an infection control risk.

### Environment and equipment

- Equipment for patients' homes was ordered on-line via an equipment store and equipment was accessible seven days a week.
- Staff received mandatory training for manual handling. Staff had access to a community manual handling team who could perform joint visits if there were complex moving and handling issues in patient's homes.
- Staff reported some delays in accessing equipment for bariatric patients and we saw this was on the community services risks register since September 2014. However, it was unclear what progress had been made.
- The community nursing teams used glucometer machines to monitor patient's blood sugar levels. We were informed by an administrator that there was a

## Are services safe?

monthly safety control in place with the laboratory. No reports for this process were available at the team and we were advised they only received a report if the machines were out of the test range.

- There were 35 syringe driver pumps available to community nursing services. Of these 35 pumps, 11 were overdue their yearly maintenance check at the time of our inspection
- We visited treatment rooms at the Forum Health Centre and Burnage Health Centre and found the rooms to be spacious, visibly clean, and accessible. We saw the yellow bag system in place to dispose of clinical waste, and hand gel was available. Sharps bins were situated on the walls, and were labelled and closed when not in use. There were no fridges within these treatment rooms.

### Quality of records

- Paper held records were used across the community services we visited during our inspection. Community nursing records were held by the patient in their home setting. Treatment room notes were stored in the clinic room. Therapy staff transported patient records when visiting patients in the community and therefore had access to up to date information with regards to the patient's progress. There was a base held record for patients receiving nursing care that held demographic patient details and reason for admission to the caseload but this record did not have a chronological recording of the patient's care and was used to record activity such as telephone calls to the service.
- We reviewed 16 community nursing records. We found all the records were not complete. Nursing assessments were not fully completed, risk assessments were not completed, and there was a lack of documented consent to treatment. As part of the transforming community services the community services became integrated with the trust in 2011. We found that the nursing assessment documentation still had the previous organisation's logo and name and not the UHSM trust logo.

### Cleanliness, infection control and hygiene

- Staff complied with the trust's policies and guidance on the use of personal protective equipment and adhered to "bare below the elbow" guidelines.

- There was ample access to hand washing facilities and personal protective equipment such as aprons and gloves in the treatment rooms we visited.
- In the health centres we visited, there was a good amount of seating in waiting areas and they appeared visibly clean and tidy.
- The trust reported on hand hygiene audits on a monthly basis. All hand hygiene audits submitted for community services for July, August and September 2015 were 100% compliant. However, not all teams sent audits each month. There were 16 teams identified on the trust report for community services with six audits returned in July and August 2015, and four returned in September 2015. We did see evidence to address this via the patch leads meeting minutes in January 2016.
- We observed the handwashing audit results of 100% compliance for part of January 2016 displayed in the integrated community nursing team office at Brownley Green Health Centre and were informed there was an infection control link nurse within the team.
- We observed syringe driver pumps at one base and found them to have an 'I am clean sticker' in situ which identified they had been cleaned after patient use. We also observed 'I am clean stickers' on equipment in the treatment rooms we visited.
- The community adult services had an 85.4% compliance for attendance at infection control training in December 2015 which was within the trust target of 85%.

### Mandatory training

- In December 2015 the adult community services as a whole were achieving 89.9% compliance with mandatory training and were achieving the trust target of 85%. Data provided identified that the out of hour's community nursing team were achieving 76.6% compliance and were underachieving the trust target as an individual team.
- One community nursing team lead told us they had been unable to allow staff to attend mandatory training on six occasions in the last three months however; this had not been recorded as an incident. Some mandatory training had become available online which had been easier for staff to access.

### Assessing and responding to patient risk

- Band five nurses and health care assistants told us that handovers rarely took place. We did not observe any

## Are services safe?

handovers taking place during our inspection at Brownley Green, the Forum health centre or the Burnage health centre despite being on site at the times we were informed by the trust the handovers took place.

- We found no evidence recorded that handovers had taken place in community nursing integrated teams. The staff at the Forum health centre told us they did have handovers, when we asked how they recorded what actions were needed to be completed for patients they informed us it was written on the patients' card. Each patient had an index card which held their name, address, contact details, door code, and the reason for the home visit. This card was placed in one of the seven boxes depending on which day of the week they required a visit. The staff took this card out with them when visiting the patient.
- One band five nurse told us if a patient was deteriorating and approaching end of life they would inform the GP and the senior nurse on duty for the team, the GP would prescribe the anticipatory drugs that may be required.
- We found a lack of risk assessments completed in the 16 nursing records we reviewed. There was no nutritional risk assessment on admission in nine records, and no falls risk assessment completed in ten records. Of the 16 records reviewed 9 had a recorded Waterlow Score at the time of the first visit. Of the nine patients assessed on the first visit, eight were identified as being at risk of developing pressure damage. Of the eight identified at risk, only four had a management plan in place. We saw no evidence of regular weekly reassessment.
- We observed a handover taking place in the integrated therapy team where discussions took place about new and current patients on the caseload and resulted in clear allocation of responsibility for tasks.

### Staffing levels and caseload

- The community nursing service had experienced a period of transition following a consultation process which began in January 2015. The consultation concluded with a final consultation paper available from 5 June 2015. Following the consultation, since September 2015, the services of active case management, district nursing, neighbourhood teams, and rapid response were integrated under one structure.
- The consultation paper had identified that since April 2015 the service specification for integrated community

nursing services were funded for an establishment of 120.57 whole time equivalent (WTE) staff. Of this establishment, 6.27 WTE staff were administrators which resulted in 114.30 WTE clinical staff.

- Data provided by the trust identified 98.9 WTE staff were in post in January 2016 against an establishment of 115 WTE, equating to 16.1 WTE vacancies. All vacancies were out to advert at the time of our inspection and there were 7.2 WTE staff awaiting start dates.
- The clinical lead, community matron and senior nurses told us that all the services provided by the separate teams prior to integration were to be continually provided within the new structure. Staff based within the integrated community team based at Brownley Green Health Centre informed us this was having a negative impact on their ability to complete all their work in particular the recording of their face to face contacts.
- There was no caseload weighting tools used within the community nursing service to monitor the complexity of the caseload. It was difficult to assess whether caseloads were appropriate as there were no dependency assessment in place and it was not clear if the acuity of patients' needs were considered as part of the workload allocation.
- As part of the formal establishment of the Community Services Directorate in April 2016, the trust informed us that budgets and staffing would be reviewed.
- Therapy services had also been transformed and were provided as part of an integrated team which included physiotherapists, occupational therapist, and speech and language therapists. Data provided by the trust identified a 0.61 WTE physiotherapy vacancy as at December 2015. The integrated therapy service had one locum in post and had no posts out to advert at the time of our inspection. As at December 2015 the sickness rolling rate for community therapy staff was 0.9% which was well under the trust target of 4.4%.
- We saw three recorded incidents between 1 September to 31st October 2015 where staff had raised concerns about workload and staff feeling stressed and unable to take breaks
- The tissue viability service had one staff member going on maternity leave but had an advert out to recruit to backfill the post for six months.
- We reviewed off duty for the integrated community nursing services for October 2015 for Withington, Baguley and Northenden. The day service was covered

## Are services safe?

from 0800-1800 which differs from the consultation paper: however, when we asked managers they told us they did not have enough staff to cover the extended hours with the current day service but that this would resolve once vacancies were recruited to. There were three staff on long term sickness and one staff member on maternity leave on the October 2015 off duty and a staff member leaving during the month.

### Lone working

- Lone worker devices were not provided to staff in the community however, staff were provided with a mobile phone.
- During our visit we asked a staff member to access the lone worker policy on the trust intranet. The staff member was able to access the policy; however, the policy had been in place since July 2012 and there had been no review date planned.
- We asked the senior nurses based at Brownley Green health centre and staff based at the Forum health centre how they knew staff were safe at the end of each shift. We were told that staff text in to the band six however, there was no evidence of a robust system which confirmed staff were safe at the end of their shift and there was no identified person responsible to ensure staff were safe. There was no system in place to determine staff had turned up for duty if they were going straight out on visits.
- Staff took the patient's card out with them when they did a home visit. Visits were written in an office diary under the person performing that visit. This was the only system in place to enable other staff to know where staff were visiting. We checked the office diary in Brownley Green Health Centre and found out of 18 days during January 2016, visits were not written in the diary on seven days. This resulted in staff lone working with no team members having knowledge of where they were visiting. During out of hours staff went out in pairs to all visits in the evenings and overnight to ensure their safety.

- Staff we asked at both health centres knew how to escalate a concern if they thought a staff member was missing.
- Staff had access to a work mobile phone and out of hours staff also carried a pager.
- The integrated therapy service had introduced a buddy system and they sent a text to each other at the end of their shift. In the office they had a diary sheet with their visits on so team members knew who they were visiting and approximately what time they should return. An occupational therapist told us there was one occasion when they went out to do visits at 0900 and had not returned by lunch time. They were contacted by a member of the team to make sure they were safe.

### Managing anticipated risks

- Failure to deliver nursing services due to reduced staffing levels was entered on the community risk register in May 2015. All vacancies were placed on hold in June 2015, and in November 2015 a recruitment plan was put in place. Control measures identified to manage the risk were prioritising of the workload, recruit to posts, and monitoring of incidents. The action identified was a daily assessment of safe staffing levels and a formal escalation plan. At the time of our inspection the trust had no process in place to determine safe staffing levels despite the integration of the nursing services since September 2015.
- An occupational therapist told us they received weather warnings via email but was not aware of the policy for adverse weather conditions.
- There was no clear process in place to identify the most vulnerable patients on the nursing caseloads should a major incident or adverse weather occur.

### Major incident awareness and training

- Staff we spoke with in community nursing were not aware of what their service were expected to do if there was a major incident.
- We were not assured that staff in nursing and therapy services were aware of the trust's major incident policy.

## 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 adult services as 'requires improvement' for effective.

Patients were not being assessed in line with trust policy to protect patients from harm free care with particular reference to nutrition and risk of pressure damage. The outcomes of peoples care and treatment was not regularly or robustly monitored in community nursing and there was a lack of external audits and benchmarking.

There was no process for determining which practitioner was responsible for coordinating the patients care when receiving care from the community adult services. We were not assured that patients were receiving best practice as we saw that some clinical policies were out of date and other clinical policies were not being adhered to.

There was a lack of documented evidence to support that consent had been obtained from people receiving care. Staff had been redeployed into positions that they did not hold the required qualifications for and we were not assured that staff were competent to deliver quality care within the community nursing services. Prior to the integration of community nursing services, and at the time of our inspection, a training needs analysis had been identified but not completed.

We were not assured that staff were competent to use equipment and there was no process for this to be regularly reviewed. There were no team held records that showed that staff had received training to operate equipment and that they had met the competencies.

There was no access to electronic referrals during weekends and bank holidays as the single point of access was not fully operational. There had been incidents which were not always reported, where patients were not visited when the patient had expected following discharge from hospital. The trust was in the process of recruiting staff to support the single point of access during out of hours.

The community nursing services in September 2015 were under achieving the number of contacts by 35%.

There was regular structured supervision within the therapy services and all staff had received an appraisal in the 12 months prior to our inspection.

There was good evidence of different professional teams working together to support people with multiple needs. This was particularly evident in the integrated therapy service.

Therapy services monitored patient outcomes and had a process in place to receive feedback from people who used their service.

### Detailed findings

#### Evidence based care and treatment

- The trust had a range of policies and clinical guidelines available to staff. These were held on the trust intranet and were readily accessible to staff in the community.
- We viewed the pressure area management policy which clearly stated that following a first visit the results of a skin inspection were to be recorded and identified on the body map. The Waterlow Score that identifies patients risk level of pressure damage was to be completed at the first visit, and any patients with a risk score of 10 and above were to be reassessed weekly if receiving regular visits. The records we reviewed and the findings from the trusts own RCAs identified that this policy was not being adhered to. We saw NICE guidelines available in patient held records in relation to pressure ulcer prevention and management however, did not see care plans incorporating these guidelines for all patients identified with a risk.
- The tissue viability nurses (TVNs) attended the North West TVN forum where wound care products were evaluated and a North West product formulary was agreed. The team monitored adherence to the formulary and the medicine management team informed them if products were ordered outside of the agreed formulary.
- The TVNs had reviewed standards for equipment checks and the documents were in the process of being ratified at the time of our inspection.

# Are services effective?

- The leg ulcer management policy was out of date at the time of our inspection and had been due to be reviewed in 2011. The TVN advised us that there were plans to develop the referral criteria prior to reviewing the policy.

## Pain relief

- Community nursing services provided care to patients that were palliative and approaching end of life. When a patient was identified as approaching end of life the GP would prescribe anticipatory end of life drugs to prevent any delay should the patient's condition deteriorate.
- Staff had access to equipment should they need to administer pain relief medication and patients approaching end of life were prioritised.
- Staff working out of hours had access to GPs if required and did not raise any concerns in relation to availability of medication for pain control.

## Nutrition and hydration

- We observed nutrition assessment as part of the community nursing assessment tool and also as part of the pressure ulcer risk assessment. However, we only saw evidence of nutritional assessment on four of the 16 sets of nursing records we reviewed. On one of the records that had a nutritional assessment a problem had been identified; however, there was no care plan in place to address this and no date to review.
- The nutrition service was at risk at the time of our inspection and it was not clear if the service would remain after April 2016.

## Technology and telemedicine

- The trust had provided the community nursing staff with laptops; however these were not yet being used within the patients' home as all patient records were paper held. Staff identified that they could not always access the trust intranet due to connectivity issues and we saw that information technology was reported on the risk register.
- Clinic appointments were made at health centre receptions onto an electronic system.

## Patient outcomes

- The tissue viability service informed us there was a target to reduce the number of grade two pressure ulcers developing on the community caseloads by 20% and at the time of our inspection this target was being met for community services.

- The nutrition team were not reporting on any patient outcomes and were only recording the number of contacts performed by the service.
- Nurses at Brownley Green Health Centre told us that care they provided was mostly reactive based on patient need rather than proactive. Routine visits for chronic disease management reviews and equipment checks were often delayed due to workload demand against available staffing. However, they did not report this as an incident.
- The integrated community therapy team had recorded 100% positive patient feedback for 61 responses in relation to patients feeling involved in decisions about their care in April to June 2015.

## Competent staff

- Following the community nursing consultation, there was a planned reduction in the senior clinical leadership posts; however, the trust had planned to increase the number of band six posts. Staff that were employed in a band six post prior to the integration and worked in the neighbourhood teams had been placed in the integrated team. Staff working in the district nursing service prior to the integration were expected to have the specialist practitioner in community nursing qualification to be able to hold a band six position. We raised this with the community matron and the integrated services manager and both confirmed that four staff would be sent to attend the training in 2016 and this would include two of the redeployed band six staff, and two band five staff.
- The trust used the T34 syringe driver pump to administer sub-cutaneous medication to patients approaching end of life. There were 15 nurses across the community that had attended a training update in the 12 months prior to our inspection. Data provided by the trust identified one nurse that had attended for the out of hour's service. Two senior community nurses told us that staff received syringe driver pump training as part of their induction and there was no yearly update.
- In all the community nursing teams we visited there were no staff competencies held for equipment that staff operated.
- The tissue viability team provided pressure care and leg ulcer management training to community staff. Staff were assessed against competencies; however there had been a reduction in the number of community staff attendance since the integration of the nursing services.



## Are services effective?

- In the TVN team staff were encouraged to develop. At the time of our inspection one team member had recently completed the V300 non-medical prescribing course; another member was on the degree pathway and had completed the mentorship programme. The team attended education sessions provided by wound care companies to maintain up to date knowledge of wound care products.
- The TVN lead nurse attended NHS England Greater Manchester Pressure Ulcer Group.
- The trust currently had a leadership development programme (LEAD) course available and one band seven nurse told us she was currently on the course and one administrator had completed the course.
- All staff in the integrated therapy service had received an appraisal in the 12 months prior to our inspection.
- Appraisal rates for nurses were requested from the trust but not received.

### Multi-disciplinary working and coordinated care pathways

- Therapy, nursing and specialist teams worked together to provide care to patients. There was no clear documentation in any of the records we viewed that identified who was the professional that was leading on a patients care.
- During a focus group staff told us that, if the patient was known to the community nurses, they viewed them as coordinating the patients care. Staff were aware and took responsibility for the delivery of care they gave. Staff at the focus group identified the GP as having the overall responsibility of the patients' care; however unless the GP had referred the patient to the community services there was no process in place to ensure the GP was aware the patient was receiving care.
- The tissue viability service worked across the acute and community which assisted with continuity of care for patients when transferred. They provided shared care with community nurses, podiatry and the continence team.
- The continence team advised us that patients that had an indwelling urinary catheter insitu were given a catheter patient passport to ensure information in relation to the catheter was shared across a patient's journey.
- There were meetings held at GP practices that staff could attend to discuss patients.

### Referral, transfer, discharge and transition

- All new referrals to the community nursing service were received electronically or by phone via the SPA. There was one WTE band three administrator currently employed to manage this function Monday to Friday 0830 to 1630. In the evening the phone was diverted to the community nursing out of hour's phone and at weekends a person was nominated to collect the phone and respond to urgent contacts.
- We were told by the clinical lead and the administrator that the wards at Wythenshawe Hospital were aware to fax referrals direct to the nursing teams during weekends and bank holidays. The administrator informed us during our visit that she had seen referrals sent to her at the weekend which had resulted in patients not being visited. This was also raised by a senior nurse; however neither the nurse nor the administrator had reported these as incidents so we were unclear what impact this was having. We did not see this risk identified on the community risk register; however during our inspection clinical managers told us they were going to recruit an additional three WTE administrators to provide cover for the SPA.

### Access to information

- Referrals were sent from SPA to the nursing teams. Information was shared across community adult services and was paper based.
- Some staff that had worked in the neighbourhood teams had access to electronic blood test results and hospital data however, not all staff could access this.
- Information and policy guidelines were accessible to staff via the trust intranet.

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

- We observed patients giving informed consent to treatment but there was a lack of consent documented in patient records. We viewed 16 records for community nursing and consent to treatment was documented in five records. We saw consent to share information documented in the patient held records and member of nursing staff told us that the form should be completed for every patient.

## Are services effective?

- As part of the trust mandatory training, staff received training for Deprivation of Liberty Safeguards, Mental Capacity Act, and dementia. Mental Capacity Act training figures were requested from the trust but not received.

## Are services caring?

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

### Summary

We rated Community adult services as 'good' for caring.

People were treated with dignity and respect during interactions with staff.

Staff explained treatment and interacted well with patients. Staff were compassionate and supported people and those close to them to cope emotionally. People were able to ask questions, discuss care, and were involved with decision-making.

The services received positive comments about the staff and the care provided.

### Detailed findings

#### Compassionate care

- We observed care being delivered with empathy and compassion.
- Community nurses were observed having a good rapport with patients during visits and acted in a very caring manner. One patient told us "the nurses are always very nice and helpful."
- Patients receiving care in clinics told us they didn't feel rushed by staff and that staff listened to them. However, two staff expressed concerns that time with patients had been reduced due to workload pressures.
- We observed patients in treatment rooms having their privacy and dignity maintained by being treated in a private area.
- All of the staff we spoke to demonstrated a passion to deliver good care to patients.
- The tissue viability nurse (TVN) team were proud of the care they gave and were passionate about improving care.

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

- During our inspection we observed patients receiving ear syringing being given advice by staff and written information leaflets.
- Patients receiving care in treatment rooms were observed asking questions, discussing their care, and involved with decision-making about their care.

- We observed carers being involved with care during home visits; however, there was no evidence of carer and family involvement documented in the patient records where this was observed.
- The continence team involved family with the patients' care, if the patient provided consent.
- The integrated therapy team discussed care with patients and recorded their agreed set goals. The patient's family or carers were asked their opinions with regards to the patients' needs and there were specific sections within the documentation where this was recorded.
- There was access to language interpreters and staff we asked knew how to access the service.
- The trust provided training on dementia care, there were dementia link nurses within teams and we saw a dementia board in one nursing team office with information and updates. Training figures for dementia training were requested from the trust but not received.
- Nurses worked with providers of social care to meet patients' needs; however, there was little evidence of this joint working documented in the patient's record.

#### Emotional support

- One patient told us "it's not like having a nurse it's more like having a friend".
- The Macmillan team offered support to community nurses, patients and their families in palliative care and end of life.
- Staff told us they offered support to service users especially when providing palliative care and agreed extra support visits, where required.
- The nursing out of hour's service told us that, if a patient died out of hours, the family had to contact a different service to inform a General Practitioner (GP). There was one occasion when a family member contacted the nurses first. To provide the family with support the nurse offered to make contact with the GP service.
- We did not see evidence in patient records within the community nursing service of patients being assessed for depression or anxiety.

# 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 adult services as 'good' for responsive.

Referrals to services were prioritised to ensure patients with urgent need were seen in a timely manner. There was easy access to clinic premises and the referral process took into consideration the holistic needs of people using the services. We saw evidence of flexibility to meet patients' needs should they be unable to attend a designated clinic.

Improvements in service delivery had resulted in a significant reduction in waiting times for therapy services since they had become an integrated service.

Staff were trained to support people in vulnerable circumstances and had timely access to additional services if required.

The tissue viability service was meeting their urgent response targets and the time of our inspection: however, there were discrepancies in the data that the trust presented to us in relation to response times. This being the case, we were not assured of the accuracy of the trusts data reporting systems.

People who used services were given information how to complain or compliment services: however, informal complaints were not reported or monitored and were resolved at local service level. This resulted in not all complaints being recorded and monitored which could have a negative impact on services learning from complaints.

Due to workload pressures community nurses had not attended the allocated leg ulcer clinics which had resulted in the tissue viability service having to run two clinics at the same time. This had a negative impact for patients as it increased their waiting time: however, the staff ensured all patients attending received treatment.

An equality impact assessment was performed as part of the consultation for integrated community nursing services; however, the impact focused on staff and not patients.

## Detailed findings

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

- Therapy staff and nursing staff provided care in patients' own homes if they were unable to attend a clinic session.
- Nurses offered treatment room sessions at the Forum health centre. A patch lead told us how one of their patients was unable to attend the Forum and needed treatment early in a morning due to work commitments. The team had accommodated this and offered a service at an alternative clinic closer to the patients' home.
- The therapy service had reduced their waiting times from several weeks to less than eight days since they had integrated therapy services.
- Staff had access to members of the multi-disciplinary services within the community and were able to refer patients to the services to meet patient's needs.

### Equality and diversity

- Staff received training for equality and diversity on induction and annually as part of corporate mandatory training.
- We saw an equality impact assessment had been performed prior to the integration of the community nursing services. The equality impact assessment addressed staffing concerns however the impact of the change for patients was not included.

### Meeting the needs of people in vulnerable circumstances

- Staff could access translators via the hospital switch or online and there were contact numbers on leaflets if an alternative language was required.
- Staff received training on dementia and worked with patients and their families to support patients with dementia.
- Community nurses gave us an example from when they were visiting a patient with learning difficulties that was resident in a unit run by social services. The patient's condition had deteriorated and did not want the patient to go into hospital. The family had power of attorney for

## Are services responsive to people's needs?

health the nurse involved the GP to complete the statement of intent, and the do not attempt cardio-pulmonary resuscitation (DNACPR) form. The patient's condition improved and the statements were removed.

### Access to the right care at the right time

- The TVN service had a target to respond within 72 hours to any incidents reported in relation to grade 3 and above pressure ulcers. They were achieving the target and had responded to eight in the timeframe in January 2016.
- The TVN service told us that community nurses were not attending the planned leg ulcer clinics and the TVN team were left to run the two clinics. We asked how often this had occurred in January 2016 and it was every week. The impact on patients was that they were left waiting longer for their treatment. Staff told us they kept patients informed and they had not received any formal complaints from patients.
- Referrals to the integrated therapy service were triaged by therapy assistants and were allocated to team members. Staff and clinical leads for the service told us there had been a significant improvement in the reduction of waiting times since the services were integrated from seven weeks to less than eight days.
- Nurses told us that they responded to unplanned contacts and prioritised visits to end of life patients.
- The community services activity report for September 2015 identified an average waiting time from referral to first contact for community nursing of ten days year to date. The same report had identified a 59 days year to date waiting time for tissue viability referrals. This did not reflect the response rates that the tissue viability service had reported to us during our inspection. We found the way the activity report was presented did not reflect the current integrated services and data was presented as the original services.
- During April to September 2015 the average waiting time to see a community nurse was ten days. Community nurses triaged referrals that were urgent and received 3211 urgent referrals for this period. Following triage 1651 were seen within 48 hours with 1388 of these being seen in 24 hours of referral.

- Patients we spoke to at the time of our inspection that were waiting to receive treatment in the treatment room had been waiting less than 15 minutes to be seen.
- In September 2015 the integrated community nursing services as a whole reported an underachievement of 35% for patient contacts against planned activity and slot utilisation was 86.2%.
- The community services activity report, November 2015, had identified the average length of time a patient was on the community nursing caseload for was 56.9 weeks. This would indicate that the nature of the patients were extremely complex, had ongoing needs, or that staff were unable to spend time to accurately update the electronic activity system to discharge patients.
- In the treatment room clinics staff informed us that the administration staff input the contacts on the electronic activity system for them. In November 2015, 1716 contacts were recorded which was 13% higher than the planned activity.

### Learning from complaints and concerns

- Formal written complaints were collected centrally by the trust and were responded to within the target timescales. There were no active complaints in relation to the community services we inspected at the time of our inspection.
- A nurse lead told us about an informal complaint about a nurse taking blood when the patient was eating. The lead visited the patient and family, gave them the opportunity to discuss their concern, an apology was given and staff were informed this was not good practice. This had resulted in a formal complaint not being made.
- There was no process in place for recording informal complaints so these were not monitored. This meant that the trust did not have a clear oversight of all complaints received in relation to adult community services.
- We observed a patient leaflet in the patient held record during the home visits we attended, which detailed how they could make a compliment or complaint.

## 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 adult services as 'requiring improvement' for well led.

The trust had followed a consultation process with staff on the proposed integrated nursing model. There were discrepancies within the consultation document which raised concern on its fitness for purpose.

The impact of the introduction of the integrated community nursing service on the quality of care was not addressed within the consultation document, was not previously understood, and was not being monitored. Managers informed us that they were using the complaints rates as an indicator of quality of care: however, we found complaints were being resolved at service level before they became formal and there was no process in place to capture informal complaints.

Data provided by the trust identified that the community nursing services were underachieving on the contract for the number of patient contacts. Staff reported a lack of time to input contact data on the system due to workload pressures and managers were aware that all contact activity was not being recorded. We saw no contingency plans in place to ensure data being reported truly reflected the community nursing service activity.

When serious incidents were reported and investigated we found that actions identified to improve practice were not always implemented which resulted in a lack of active learning from incidents and could result in the patient being at risk of harm. We found a lack of timely managerial oversight of the allocation of work and caseload management. Following the integration of community nursing services the trust had not completed a training needs analysis prior to the integration or at the time of our inspection. Staff had been redeployed into roles which they did not have the competencies for. Managers had identified a need to send more staff on the specialist practitioner training: however, there was a lack of a contingency plan how this issue was being managed at the time of our inspection.

Data provided by the trust had identified a 67% increase to the community nursing caseload in September 2015: however, we did not see this identified as a potential risk or any contingency plans to manage access and flow within the service.

There was evidence of low staff morale within integrated nursing services following the integration and in the nutrition service due to no decision made about their future role. Morale within the integrated therapy services was good: however, the therapy services integration had not resulted in changes to staff banding or reduced numbers of staff. Morale within the tissue viability service was good and staff felt supported and were given opportunities to develop.

Staff identified good leadership at team level and valued team support from their colleagues.

### Detailed findings

#### Service vision and strategy

- The trust was aware of the significant challenges within community nursing services and had plans in place to address them. These challenges included understaffing within nursing and upskilling and training for redeployed staff.
- Staff had been involved in the community nursing consultation process; however, some felt that plans identified in the paper were not being delivered. These were in relation to staffing and shift patterns.
- As part of the devolution Manchester project which involves coordinating health and social care services together, the trust had planned to have a new community directorate from April 2016 and staff we spoke with were aware of this change. Staff felt that this would give community services more priority as previously they thought the trust was focused on hospital care rather than community.

#### Governance, risk management and quality measurement

## Are services well-led?

- Community services sat within the unscheduled care division alongside medical wards and urgent care services. There were plans for community services to have their own directorate and governance arrangements from April 2016.
- Risks and incidents were submitted at divisional level, we observed meeting minutes that demonstrated this. Clinical leads we spoke with in community nursing, therapy and specialist services knew what their risks were; however, additional risks were identified at the time of our inspection that were not recorded on the risk register which included: poor completion of risk assessment, skill mix and competency of staff, and lack of acuity and caseload management tools.
- We saw evidence of risks being discussed at the complex health and social care governance monthly meeting however there was lack of sharing lessons learnt with local teams at service level.
- Risks had review dates but risks remained on the register for lengthy periods without resolution, in particular the access to bariatric equipment which had been on the register since September 2014.
- There were no consistent, clear quality measures for community nursing services. We asked staff how they knew they were doing a good job and they told us patients thanked them and they had no complaints, senior managers and clinical leads told us there was no increase in complaints. The NHS friends and family test was used to gain staff feedback on services with 60% of community staff responses in September 2015, not recommending the trust as a place to work.
- The changes made to integrate the nursing service were not being monitored and reviewed. When we asked senior leaders and managers they advised us that they were using complaints to determine if quality of care was being compromised. However, there was no process in place for monitoring and reporting informal complaints.
- The NHS safety thermometer which is the national improvement tool for measuring monitoring and analysing patient harm and 'harm free' care was not completed for any of the community services we visited during our inspection. The trust was using the electronic incident reporting system to monitor pressure ulcer damage; however, there was limited evidence of quality measurement or improvement at local level.
- Following a review of a route cause analysis for a serious incident in relation to a pressure ulcer, we saw that a documentation audit was identified within the action plan and was to be completed throughout December 2015. We requested the results of the identified audit: however, the trust advised us they were unable to locate this audit. Therefore we were not assured that actions identified following serious avoidable harm were being implemented.
- We met with the community matron and the deputy directorate manager who informed us that the establishment identified from the consultation was being used to staff the service. We viewed the agreed final version of the community nursing consultation dated 5 June 2015. On review we found a number of discrepancies within the document with regards to staffing establishments. We found calculation errors, and differences within the main body of the document and the WTE recorded in appendix four and appendix five.
- We received from the trust an update of the staffing at the 25 January 2016 and found the WTE identified on the document to be slightly different to what the staff had received dated the 19 January 2016.
- The staff working out of hours told us that they were still covering the service from 18:00 every evening; however, the consultation document had identified that the day service would cover the service each evening until 20:00. The community matron and the deputy directorate manager were aware of this but this was not recorded as a risk on the risk register and were informed that the recruitment of band five nurses would enable this to be resolved.
- Patient contacts for nurses in November 2015 were recorded as 6098 which was 51% below the planned target. The number of reduced contacts could be a reflection of the staffing vacancies and additional workload pressures. Senior managers, senior lead, and staff all recognised difficulties recording all contacts yet we saw no provisional solution being considered to ensure activity was being accurately input.
- Staff were not always following the trust's policy for incident reporting. This meant there was a risk of incidents being under reported. Staff told us, when they did report incidents, they rarely got any feedback from managers so felt despondent in reporting further incidents.

## Are services well-led?

- The therapy services collated a range of patient outcomes and fed these back to the trust.
- City wide governance meetings took place in relation to the forthcoming integration of health and social care services however plans for this which was planned for April 2016 was delayed.
- The community matron was aware of a divide between hospital and community and had plans to set up joint performance meetings and joint training with ward managers.
- The manager of integrated services was aware that the integration of community services had resulted in inequity in relation to the competencies for a band six community nurse. There was a plan in place to resolve this by enabling relevant staff to access the specialist practitioner course: however, we did not see this on the risk register and were not assured that this had been risk assessed in the interim whilst waiting for staff to be trained.
- Any clinical staff within the team could allocate the working lists for home visits. Staff told us senior staff would review the allocation from the diary: however, we had seen that the diary was not always completed and were advised that they could review during handover but the majority of visits would have been completed by then. This being the case we were not assured that there was timely managerial oversight for caseload management and allocation of patients within the integrated community nursing teams.
- Data provided by the trust had identified a 67% increase to the caseload of community nursing in September 2015. The trust advised us that there would be a review of the nursing staffing establishment following the integration of community nursing services.

### Leadership of this service

- Staff in the services knew who their immediate leads and managers were and described them as supportive and approachable. They were aware of managers higher than this, but had not met them and said they rarely visited the services.
- Staff knew which directorate they were in and were aware that the community services were to have their own directorate from April 2016 which they thought was a positive move for community services.
- Due to the integration of community nursing services, a number of experienced staff had left the trust. The quality impact assessment performed in June 2015, as

part of the consultation process, had identified the need for a training needs analysis to identify training needs and gaps. We requested a copy of the training needs analysis; however, the trust informed us that this had not been completed. Re-deployed staff did not have skills to perform their new roles. Managers were aware of this and stated they would be offering additional specialist practitioner placements: however, we did not see this as a risk on the register.

- The nursing patch leads, community matron, and integrated service manager were new to their roles and most had been in post for less than six months. The trust offered leadership training for staff and we spoke to a patch lead that was on the course at the time of our inspection.
- There were no formal regular one to one meetings with staff taking place in the community nursing teams we visited. In the integrated therapy team, band seven staff had supervision every two months, all new Band seven staff (for the first year) and Bands six, four and three staff had supervision every month. A dietician told us they no longer received supervision, and the continence service held monthly one to ones. Staff told us they could go to their managers if they had any issues and there was an open door policy.
- Staff told us they did not feel supported by managers. They were unable to take two days protected non clinical time as specified in the new integrated model due to the clinical workload.
- When asked, staff did not know what the team establishment should be since the integration had taken place. They showed us a copy of the establishment but stated that the staff identified in the patch team was not actually in the team at that time.
- The nutrition service was informed 14 months ago that they were at risk and at the time of our inspection staff were still waiting to hear if they were being redeployed or made redundant.
- An occupational therapist told us that they see their direct clinical lead managers daily as they are based in the same building but, said they did not see managers higher than them.
- The nursing out of hour's service staff told us their manager had not been to any of their meetings since October 2015 however, clinical managers told us during our inspection that they had arranged dates during the week of our inspection to meet them.



## Are services well-led?

- The matron for community nursing had recently introduced weekly patch lead meetings. There had been a meeting the week of our inspection and the discussions at the meeting included inputting contacts, outcomes to incidents to be recorded on the incident reporting system, patch leads were invited to chief nurse meetings to integrate with the hospital staff more. This was a new initiative: however, one patch lead had attended and had found it beneficial to understand and share hospital and community challenges.
- We saw at one base the accreditation assessment had been completed in March 2015 and the team achieved a bronze status. Actions identified for improvement included identifying a dementia lead, and to identify when equipment was clean, both these actions were completed. The trust had a plan to review actions with a follow up visit six months after assessment however, this had not taken place and we saw the risk of being unable to complete these assessments identified on the risk register.
- We asked staff in the community nursing team how they knew they were providing a good effective service. Staff were aware that there was a family and friends test and a patient questionnaire had previously been used. The community matron told us that friends and family tests monthly reports were sent to band seven staff. No members of the team we asked were aware of the results from these processes. They told us they got thank you cards and chocolates and patients thanked them and they had received no formal complaints.
- Staff at a focus group told us they were not sure if they would have a job in April 2016 due to changes and despite raising concerns to managers had not received a conclusion.

### Culture within this service

- A member of the nutrition team told us they were proud of what they were doing for patients in terms of giving them care and advice.
  - The therapy team were proud of the way they had integrated and reduced their waiting times.
- Staff were proud of the good team working at service level however one lead told us it was a challenge to keep staff motivated.
  - At the time of our inspection we found morale to be particularly low among staff in the community nursing out of hour's service, and within the Brownley green integrated community nursing team.
  - Directorate leads and senior leaders were proud of staff resilience.

### Public engagement

- The integrated care service manager told us there had been a lack of patients involved in the development of the integrated community services. Local voluntary organisations had been contacted, and contact had been made to patient participation groups.
- Staff were aware of the NHS Friends and Family questionnaire but were unaware of any results.

### Staff engagement

- Monthly meetings were held in the nutrition team, tissue viability team and therapy services and minutes were distributed. The community nursing staff attended team meetings and we saw some notes of the meetings during our inspection and the community matron had recently introduced a weekly patch lead meeting. The trust participated in the NHS friends and family test which allows staff to give feedback on services they provide. In September 2015 the community services reported that 60% of staff would recommend the trust as a place to receive treatment and 40% would recommend it as a place to work.

### Innovation, improvement and sustainability

- The community services were moving into their own directorate as from April 2016 and there were plans to provide one integrated health and social care provision to people in South Manchester.
- The integrated therapy team had been nominated for the team of the year award for their integrated approach to care for patients in the community.
- Due to the increase in nursing caseloads and staffing vacancies sustainability was a risk.

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.