Stockport NHS Foundation Trust

RW6

Community health services for adults

Quality Report

:

Date of inspection visit: 19-22 January 16
Date of publication: 11/08/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
	Ann Street Clinic		
	Ashton Primary Care Centre		
	Bramhall Health Centre		
	Crickets Lane Health Centre		
	Hazel Grove Clinic		
	New Century House		
	Woodley Health Centre		

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

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
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

Overall, we have rated community adult health services as Requires Improvement.

Stockport NHS Foundation Trust provided a wide range of community-based health services for adults, supporting health and wellbeing promotion, minor ailments, serious or long-term conditions and facilitates discharge from hospital and aim to prevent admissions to hospitals.

Services were provided across Stockport, Tameside, and Glossop in people's homes, residential and nursing homes, clinics and health centres.

The services provided included district nursing; podiatry; dietetics; optometry; continence; integrated diabetes and high risk foot teams; learning disability; adult speech and language therapy; MSK physiotherapy and orthotics.

We carried out an announced inspection on 19-22 January 2016 and an unannounced inspection on 1 February 2016.

As part of the inspection we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We spoke directly with 80 members of staff, including 35 staff who attended focus groups. We talked with people who used services. We observed how people were being cared for in their own homes and in clinics. We talked with carers and/or family members and reviewed 16 care or treatment records for people who use services.

As part of our inspection, we observed patient survey results and spoke to six patients.

We left comment boxes for patient feedback in a number of clinics. We received 223 responses.

87% of the responses were positive feedback about the service received; 2% was negative feedback and 11% was neither positive or negative.

Negative comments were mainly in relation to long waits for appointments or results; poor communications; poor information and estates.

We rated the community adult health services as **Requires Improvement** because:

- Reviews of District Nursing services carried out by NHS England and by the trust indicated that the services were operating with reduced staffing levels that had not been planned to meet the needs of the local population.Nurses' working beyond their contracted hours was not an exception but an almost daily occurrence.
- Staff reported incidents in a timely way though feedback and learning from incidents was ad hoc and did not follow any set processes.
- A number of incorrect insulin doses had been administered because of paperwork being misread and we were not provided with evidence of remedial actions taken to prevent this from happening again despite an incident being logged.
- Consent was not always recorded in patient notes.
- Clinical competencies were not being shared between services and organisations, leading to clinicians being unable to carry out their full range of duties and putting additional pressures on colleagues[FA1]. Competencies gained elsewhere were not added to "Clinical Competency Passports" and had to be regained when staff moved into Community Healthcare. This did not meet patient needs and put added pressure on colleagues who had to cover additional tasks for those staff who had not yet been re-assessed as being clinically competent in them.
- There were delays in staff receiving appropriate training and the receiving of formal supervision.
- The trust had not met their target on the numbers of staff who had received an appraisal.
- There was a lack of access to information leaflets in different languages or in braille or large print.
- Some clinic facilities and buildings were generally not fit for purpose, requiring maintenance and having floors that were inaccessible to service users.We saw that some of the doors in the more modern clinics made mobility through the building difficult for wheelchair users.

Summary of findings

- Staff did not always receive feedback and learning from complaints.
- Staff told us that members of the trust and Community Business Group senior management team were not visible in community bases.
- There was no staff retention or recruitment plan in place despite a service review identifying a shortage of District Nursing staff and a number of District Nurses (especially at Band 6 level) leaving the service.
- There were communication issues between staff above Band 7 level and those below.Staff in Tameside and Glossop Community Adults Team did not feel that they had been fully informed about their transition to Tameside Hospital NHS Foundation Trust and their concerns about working in an integrated team had not been addressed.The management board was unaware that the introduction of a clinical competencies passport was not working as intended.
- There were high staff turnover and sickness absence rates in the Community Business Group with high levels of stress-related absences, especially in Band 5 Nurses.

However:

- The Community Business Group was above the trust target for mandatory training completion.
- There was an excellent winter planning policy and staff were aware of their roles and responsibilities in the event of adverse weather to maintain services, especially for more vulnerable patients.
- There was comprehensive care planning in which NICE guidelines and local CQuIN quality innovation was used.
- There was good evidence of multidisciplinary team working that facilitated patient access and flow, appropriate discharges and helped to prevent hospital admissions or readmissions.Appropriate guidance was given to stakeholders such as care homes and carers to enable co-ordinated care pathways for patients.
- Staff were kind, caring and compassionate and made efforts to alleviate patient fears.
- Patients were treated with dignity and respect and encouraged to agree treatment aims.
- There were 'Dignity Champions' in clinics and many staff and stakeholder organisations were accredited with the Daisy quality marker (a quality standard awarded for organisations to demonstrate that they deliver a service which has dignity and respect embedded in it.).
- There was timely access to appointments and treatment.

Band 6 and 7 staff were very supportive of their teams and led by example. Team members were supportive of each other, covered the work of absentees and worked extra hours to get the job done.

Summary of findings

Background to the service

Stockport NHS Foundation Trust provided a wide range of community-based health services for adults, supporting health and wellbeing promotion, minor ailments, serious or long-term conditions and facilitates discharge from hospital and aim to prevent admissions to hospitals.

The services were commissioned by two Clinical Commissioning Groups (CCGs), Stockport CCG and Tameside and Glossop CCG and, overall, the community healthcare services in Stockport and Tameside and Glossop were run as separate entities. Tameside and Glossop Community Health joined the trust five years ago with a three year contract that had since been extended. Stockport Community Health became part of the trust nearly four years ago.

Services were provided across Stockport, Tameside, and Glossop in people's homes, residential and nursing homes, clinics and health centres.

The services provided include district nursing; podiatry; dietetics; optometry; continence; integrated diabetes and high risk foot teams; learning disability; adult speech and language therapy; MSK physiotherapy and orthotics.

Some services had been integrated, to provide equitable services across the footprint of both CCGs, for example, the Continence Team, Podiatry and the Wheelchair Service.

Some teams were multidisciplinary and integrated with local authority staff, such as social workers, to help prevent readmissions to hospital. Examples of such teams were the Community Assertive In reach Team (CAIR) who were based in the acute setting but hosted by the Community Healthcare Business Group. They were responsible for facilitating appropriate discharges and aversion of hospital admissions or early hospital discharge through assessment and treatment of individuals. They supported individuals to remain in community settings, in their own home, residential or nursing homes. The IRIS Team prevented emergency admissions to hospitals and residential care. They provided integrated care from a joint health and social care assessment, supporting primary care and community services to prevent deterioration, avert crisis and maintain clients in the community during the sub-acute phase of illness.

At the time of our inspection, there were plans to transfer the majority of community healthcare services in Tameside and Glossop to Tameside Hospital NHS Foundation Trust with effect from 1 April 2016 where adult community services will be integrated with partners in social care, the local authority and the third sector to become "Care Together" in the Tameside region. The long-term plans were for "Care Together" to become a stand-alone organisation. Stockport adult community services was to remain under the control of Stockport NHS Foundation Trust for the time being but will also move forward with a similar transformation project known as "Stockport Together".

As part of our inspection, we inspected services from 19-22 January 2016 and 1 February 2016 in seven different locations across Stockport and Tameside. The services we visited included:

- District nurses
- Nurse Treatment Room
- Leg Ulcer Clinic
- Diabetes Clinic
- Musculoskeletal physiotherapy
- Musculoskeletal Podiatry
- Podiatry clinic
- Locality Administrators and Business Support Staff
- Dignity staff

Our inspection team

Our inspection team was led by:

Chair: Gill Gaskin

Summary of findings

Team Leader: Ann Ford, Head of Hospital Inspections, North West

Inspection Manager: Wendy Dixon, Acute Hospitals, North West.

The team that inspected this service were one CQC inspector, one specialist advisor with a background in community nursing and managing community services and one observing CQC Inspector

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of experiences and their perceptions of the quality of care and treatment by the service.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection of Stockport NHS Foundation Trust

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 19-22 January 2016 and an unannounced inspection on 1 February 2016.

During the inspection we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We spoke directly with 80 members of staff, including 35 staff who attended focus groups. We observed how people were being cared for in their own homes and in clinics. We talked with carers and/or family members and reviewed 16 care or treatment records for people who use services.

What people who use the provider say

As part of our inspection, we observed patient survey results and spoke to six patients.

We left comment boxes for patient feedback in a number of clinics. We received 223 responses.

87% of the responses were positive feedback about the service received; 2% was negative feedback and 11% was positive and negative.

Negative comments were mainly in relation to long waits for appointments or results; poor communications; poor information and estates.

Summary of findings

Good practice

We found the Daisy project run by the Dignity Matron within the Trust and local external stakeholders to be an outstanding service

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- The trust should ensure the privacy and dignity of service users by stopping the sharing of treatment rooms at Hazel Grove.
- Ensure the reception area used for mother and baby clinic at Hazel Grove Health Centre is screened off to maintain service users privacy and dignity.
- Ensure that patient consent to treatment is indicated on Diabetic Clinic notes, even if this is just implied consent.
- Ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff in District Nursing services are deployed to make sure that they can meet people's care and treatment needs and keep them safe at all times.Staffing levels and skill mix must be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.

Action the service SHOULD take to improve

- The trust should consider re-commissioning a dedicated lone worker safety system or device to maximise the safety of those staff working alone in the community and out-of-hours.
- Consider that Diabetes Clinic Care Plans are clear and written on the appropriate care plan documentation.
- Consider keeping copies of care plans at District Nursing bases, as well as in the patient's home, to enable better support, clinical supervision and monitoring of compliance.
- Consider reviewing the clinical competencies passport scheme to enable competencies gained in other trusts or services to be transferable to Community Health Services and to minimise any delays where further competency training is identifiedThe trust should ensure that staff in the Communities Business Group are receiving a 12-monthly appraisal.
- Consider providing more information leaflets for patients in different languages to reflect the local community and providing clinicians working in the community with means of identifying the language spoken by patients to enable future communication via an interpreter.
- Enable better analysis of sickness absence by correctly recording reasons for sickness absence and avoid recording "no reason given".
- Look for ways to reduce the level of sickness absence due to stress-related reasons, especially amongst Band 5 staff in the Communities Business Group.

Stockport 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 health care services as **Requires Improvement** for Safe

Reviews of District Nursing services carried out by NHS England and by the trust indicated that the services were operating with inappropriate staffing levels[FA1]. The most recent review, commissioned by the trust, indicated that in Stockport District Nursing an additional 25.11 WTE District Nurses were required (a 26.4% shortfall). The same report indicated that, in Tameside and Glossop District Nursing, there was a 66% shortfall in qualified District Nurses (56.91 additional nurses).

Staff reported incidents in a timely way though feedback and learning from incidents was ad hoc and did not always happen.

Pressure ulcers formed the highest numbers of incidents and there was no plan in place to reduce the number of pressure ulcers arising

A number of incorrect insulin doses had resulted from misreading the required dose on the file, where the previous dose was also written and had not been crossed through. Though this had been reported, nothing had been done to prevent this from happening again.

Some clinics were old, required maintenance, had space issues and were generally, not fit for purpose.

The Communities Business Group was above the trust target for mandatory training having been carried out but improvements needed to be made to increase the number of staff who have undertaken manual handling training.

The quality of patient records was variable. No consent from the patient was seen on the diabetic patients' notes.

The business group had an excellent winter planning policy and staff were aware of their roles and responsibilities in the event of adverse weather.

Detailed findings

Safety performance

Requires improvement

Are services safe?

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and "harm free" care.
- District Nurses recorded safety thermometer information on medications and other risks, namely, pressure ulcers; patient falls; urinary tract infections (UTIs) and venous thromboembolism (VTE) assessments and treatments. The trust only supplied safety thermometer outcomes for community inpatient services.
- We saw a white board detailing ongoing pressure ulcers during the inspection but did not see safety thermometer information displayed elsewhere.

Incident reporting, learning and improvement

- There were effective systems and processes in place for reporting incidents. Staff used an electronic incident reporting system. Staff knew how to report incidents and were comfortable doing so.
- Tameside and Glossop Community Adults staff recorded 1791 incidents between October 2014 and September 2015. Stockport Community Adults staff recorded 701 incidents.
- We were unable to establish whether the differential in numbers was due to less incidents occurring in the Stockport area or less incidents recorded.
- The National Reporting and Learning System (NRLS) website captures and collates patient safety incident data across trusts in England. NRLS states that "Organisations with a culture of high reporting are more likely to have developed a strong reporting and learning culture". The NRLS data shows, that from April to September 2015 Stockport NHS Foundation Trust Community Nursing, Medical & Therapy Services were the 5th highest reporter of incidents in England. They were the 6th highest for the percentage of incidents reported in their own trust.reporting 23.6% of the trust's incident reports for this period. The service was a high reporter of incidents but was not a significant outlier in England. Across the Community Business Group, during the same period, one incident had a severity rating of "High" in Tameside and Glossop and one in Stockport.
- Pressure ulcers formed the greatest number of incidents recorded across both Tameside and Glossop and Stockport Community Adults. Between October 2014 and September 2015 Tameside and Glossop Community Adults recorded 751 pressure ulcers, which was 42% of all incidents. During the same period, Stockport Community Adults recorded 252 pressure ulcers, which was 36% of all incidents.
- The Community Healthcare Business Group Quality Performance Board had identified the need for an investigation to check how pressure ulcers were being recorded in Tameside & Glossop and Stockport due to anomalies in reporting. The plan was to gain assurance that pressure ulcers were being reported correctly and they were going to look at the percentage of incidents that were pressure ulcers in each area rather than the numbers. This action was ongoing.
- One District Nursing Team told us that they carried out a sample check of ongoing pressure ulcers and all were correctly reported on the incident reporting system.
- For a reported pressure ulcer, a pressure ulcer pro-forma was completed so that the nurse was able to identify whether they did everything they could to prevent it. The Nurse also completed an action plan so that something could be learned from the incident. The Tissue Viability Team assessed pressure ulcers. However, there was no high level action plan or strategy to prevent or reduce the number of pressure ulcers occurring in the first instance and the number of pressure ulcer incidents was not on the risk register.
- The next highest incident categories reported by Tameside and Glossop Community Adults for this period were 189 staffing related incidents (10.6%) and 147 low blood sugars (8.2%). They also reported 94 drug/ medicine related incidents (5.2%).
- The next highest incident categories reported by Stockport Community Adults for this period were 152 discharge related (21.7%) and 95 drug/medicine incidents (13.6%).
- A number of the drug/medicine incidents related to missed insulin doses. We were given details about several incidents. One involved a new member of staff who missed an afternoon insulin injection and tried to escalate the call to the evening service, which could have affected the patient's safety. The incident highlighted a lack of training. In Tameside and Glossop Community Nursing, where a nurse missed an insulin dose, that nurse was taken off administering insulin, counselled around insulin and was only allowed to further administer insulin with a Band 6 nurse who would check their competencies in performing the task.

Requires improvement

Are services safe?

- Some incorrect insulin doses were due to the front page of the patient's notes stating the new and previous insulin doses. If these were misread, it resulted in the patient receiving a dose that was too high or too low. The trust had not changed the page, or ensured that the previous dose was struck through, to prevent this from happening again. Nurses told us that this particular problem had been reported on the incident reporting system and nothing had changed. There was a clear lack of action and learning from this.
- We were told that, in Tameside and Glossop District Nursing, in the past year there had been 34 missed insulin doses and this equated to 0.007% of all insulin doses administered. We could not verify this as missed insulin doses were not categorised as a separate incident on the incident report figures supplied.
- Administrative staff were confident in reporting incidents. We were given examples of incidents that had recently been reported in a clinic, such as, a patient slipping on a wet floor, a child trapping their fingers in a toilet door' a patient stuck in the lift and syringes found in a toilet.
- Band 7 nurses who had received training in incident investigation received patient safety incidents. They attended a root cause analysis validation meeting and had ownership of the resulting incident action plan. Outcomes were discussed at team meetings, Band 6 meetings and at cross-communities band 6 and 7 meetings. Any emerging themes in incidents were discussed at these quarterly meetings.
- Band 6 meetings took place every two months but Band 6's reported that they did not always get to the meetings because of their location or work commitments so could not always provide feedback to staff.
- District Nurses reported that incidents were discussed with their peers at the earliest opportunity at lunchtime meetings.
- Staff reported that feedback from incidents reported was ad hoc and not always given.

Duty of Candour

- The Duty of Candour regulation is there to ensure that trusts are open and transparent with people who use services and to inform and apologise to them when things go wrong with their care and treatment. Staff were aware of the Duty of Candour.
- Apologies were given at the earliest opportunity and potential complaints were dealt with at a local level wherever possible.

Safeguarding

- Staff understood and were able to explain the process for reporting safeguarding concerns.
- The safeguarding policy was accessible to staff on the trust intranet.
- All Band 7 District Nurses in Tameside and Glossop were Safeguarding Adults Managers (SAMs). In Tameside and Glossop, there were three Safeguarding Adults Managers who rotated on duty. They were trained to investigate concerns involving vulnerable adults. The staff member on the Safeguarding Team, who dealt with adults, collated the information and distributed this to the appropriate SAM to investigate.
- The trust target for Community Adults staff trained at Level 2 Safeguarding was 95%. 89% of staff were Level 2 Safeguarding trained.
- The trust target for Child Safeguarding training Level 1 was 95%. At September 2015, across the Community Business Group, 86.38% of staff had received this training.
- We were given an example of a recent safeguarding incident raised by staff where a staff member in a nursing home was suspected of abusing a patient. A District Nurse found bruising on the patient and raised this as a safeguarding issue.
- There was a joint commissioner/provider Safeguarding Assurance Group that was chaired by the Deputy Director of Nursing and attended by Trust Named Nurses for Children and Adults and the CCG Designated Nurses from Stockport and Tameside and Glossop oversaw the work to ensure that the Trust was compliant with the 'Safeguarding Standards for Provider Organisations'.
- Level 1 Safeguarding Training was given to Administrators and Locality Managers as part of their induction

Medicines

- Controlled drugs used by District Nurse were not kept on clinic sites but were prescribed for individual patients and stored in their own homes. Nurses reported that they had good communication with local GPs and had no issues with acquiring medications for patients.

Requires improvement

Are services safe?

- District Nurses received training in the benefits of different dressings and pain relief drugs so they could make a decision about which was best for the particular needs of the patient. We saw details of the training courses given, which were comprehensive.
- In District Nursing, all Band 6 Nurses were able to prescribe drugs. At Crickets Lane clinic there were two Band 5 Nurses who were also able to prescribe.
- Drugs kept in the patient's home were destroyed at the earliest opportunity if the patient died.
- Drugs were not widely kept in clinics and we saw several fridges that were not used. A fridge that was in use was checked at Woodley Health Centre. The fridge was not locked and there was no evidence of a daily temperature log. The temperature of the fridge was within the permitted range when checked.
- We checked a stock of dressings at Ashton Primary Care Centre Diabetic Clinic. The dressings were kept in the Clean Linen Room in an unlocked cupboard. The first dressing checked expired in December 2013. No other out of date dressings were found and the clinic was to undertake an immediate check of all stocks to ensure that all were in date.

Environment and equipment

- District Nurses used syringe drivers to deliver doses of drugs to patients in their own homes. They were trained in the use of syringe drivers though not all Nurses had yet received this training. We saw details of the training course given, which was face-to-face and involved a practical assessment in the use of the model of syringe driver used by the trust.
- In Tameside and Glossop, the Palliative Care Team at Crickets Lane Clinic kept the syringe drivers. They had previously been kept at District Nursing bases. Nurses told us that when they had to collect a syringe driver, it could add a considerable amount of time onto their working day when they had to drive to collect one.
- Lone working devices used by clinicians working in patient's homes had been de-commissioned by the trust because they said that they were not being used. The devices had been personal safety alarms where pressing an alert button contacted a control centre where two way contact with an operative was enabled and GPS tracking allowed the location of the staff member to be seen. Rather than make their use mandatory they had replaced them with mobile phones. Mobile phones are not lone worker safety devices and the ability for staff to work safely in the community may have been put at risk.
- Some of the older clinics we visited were no longer fit for purpose. For example, the District Nursing office at Bramhall Health Centre was very cramped and could not accommodate the number of nurses who worked there.
- There had been issues with water ingress in other clinics and we were shown a hole in the stockroom ceiling in Bramhall Health Centre which was due to be fixed.
- Although Ashton Primary Care Centre was a new and purpose built building, staff told us about several issues with the environment. For example, the gym in Physiotherapy was not an ideal size for the number of patients they wished to treat; work stations were too high and there was a problem with ventilation in the building meaning that it got too hot. This resulted in a patient passing out. Staff felt unable to open the door of treatment rooms to let air circulate as this caused a problem with confidentiality. The ventilation and air conditioning remained an ongoing issue.
- We acknowledged that the clinic premises, upkeep and maintenance was often not in the hands of the trust and that buildings were shared with primary care services. Issues with the environment were nevertheless reported in a timely way.
- Treatment beds within treatment rooms were in good condition and height adjustable.
- We saw sufficient seating in waiting areas.
- Nursing staff said they had no issues with ordering equipment for patients' homes.
- Service contracts were in place for maintenance of specialist equipment.

Quality of records

- Clinic notes were kept in the relevant clinic. The notes for patients receiving treatment at home were kept in the patient's home and a copy at the District Nursing base.
- District Nurses used a "chitty" book which duplicated the handwritten notes so that one copy was stuck into the patient's notes in their home and a copy brought back to base to stick into the file kept there. There was a risk that these notes could become detached from the file and fall out.

Requires improvement

Are services safe?

- We examined 16 sets of patient records across District Nursing, a Diabetes Clinic and a Leg Ulcer Clinic.
- Care plans on District Nursing files could only be seen in the patients' homes as copies were not held on the file at base. Most seen were clear and detailed, up to date and included clear goals and objectives for the patient.
- We looked at the file of a complex needs patient in District Nursing and found that half the case notes were missing. They were located at a different clinic. There was a four month gap in the notes where the patient appeared to have received no contact with healthcare professionals. Electronic records indicated that the patient had been seen in this time period. There had been no re-assessment of the patient's needs when they had moved house and a new District Nursing Team took over their care and treatment.
- In the Tameside Diabetes Clinic care plans were not clear and were not always written on the appropriate care plan document but were a list of actions written in the patient notes. This meant that they were not always easy to find.
- The patient's signature of consent to treatment was seen on all the records relating to leg ulcers and all the District Nursing records in patients' homes but only one of the records held at the District Nursing base. Of the five diabetic clinic notes checked, a patient consent signature was not present.
- The fact that District Nursing care plans were only kept in the patients' homes meant that support, clinical supervision and monitoring of compliance could not easily be carried out unless viewed by a manager in the patient's home. If the initial care plan was not complete, or the wrong care had been recommended, this could lead to a patient safety issue.
- The Communities Business Group carried out monthly documentation audits. 10 sets of records in each team were audited against trust standards that required 90% compliance and the group audited another 25 sets of notes against NHSLA (NHS Litigation Authority) standards that required 95% compliance. We were unable to obtain the audit results.

Cleanliness, infection control and hygiene

- Hand hygiene audits in District Nursing were done on a peer review basis.
- The trust identified in November 2015, that there was a lack of clarity with regard to the hand hygiene process in Community Healthcare and a lack of evidence to report accurately the compliance levels. An action plan was written to develop a hand hygiene process across all services and to ensure that staff complete the relevant infection prevent audits and collate compliance information.
- The trust used a "train the trainer" model to deliver ANTT (Aseptic Non-touch Technique) training to staff.
- Staff were extra vigilant with hygiene when entering a care home where there had been an outbreak of norovirus.
- All District Nursing staff carried gloves, aprons, hand gels and clinical disposal waste bags with them.
- The trust had an Infection Prevention and Control Policy that was accessible to staff via the intranet.
- We saw audits that had been carried out in all clinics on environment and infection control.
- We saw that treatment rooms were visibly clean and tidy and observed staff washing their hands.
- We observed cleaning of treatment beds and all equipment after use to prevent cross contamination.
- Sharps bins were all dated, not over-filled and temporarily closed and secured to the wall.
- In Hazel Grove Clinic patients were informed that they may have to share a treatment room with another patient and clinician for podiatry and leg ulcer clinics. This presented an infection control risk.
- In Ashton Primary Care Clinic we found that there were no hand gels, though there was soap by the sinks. In the diabetes clinic, on the two occasions that we visited, there was a lack PPE equipment. There were no hand gels, no aprons or gloves. In the treatment room there was no blue roll being used on the bed and the dispenser was empty although a blue roll was seen on a shelf.
- Staff in the Diabetes Clinic seemed unsure as to who was responsible for ordering supplies.
- Staff in Ashton Primary Care Clinic reported an issue with cleanliness of the building. The building managers, Integral, were responsible for maintaining and cleaning the building and supplied the domestic staff. They attended between 6am and 9am and were off-site for the rest of the day. Staff had to request a deep clean of some areas as they had not been cleaned thoroughly and floor cleaning in patient areas remained an issue. The domestics would not clean any human spillage and clinicians were responsible for this. They had use of spillage kits.

Requires improvement

Are services safe?

- In Stockport clinics, there was access to a rapid response cleaning team, based at Regent House, for any urgent issues. Cleaning equipment was not kept in the clinics but spill kits were available. The clinics were cleaned every morning.
- We saw no evidence of use of "I am Clean" stickers on any equipment to indicate that it had undergone a thorough clean to prevent infection.
- Clinical waste was removed from clinics on a daily basis.

Mandatory training

- The trust target for mandatory training was 95%. The trust supplied figures that showed that, in September 2015, Mandatory training across Community Healthcare was at 96.70%.
- Manual Handling training figures were not included in the above figure. The trust target for Manual Handling training was 95%. At September 2015 87.23% of staff across the Communities Business Group had received this training.
- Administration staff in Tameside and Glossop Community Healthcare were 100% compliant with mandatory training.
- Delivery of mandatory training was face-to-face and by e-learning. Staff received mandatory training in areas such as infection control, fire safety, basic life support, patient handling and information governance.
- Staff were supported by managers to undertake the training. We saw boards in District Nursing offices displaying staff names and training due dates for mandatory and revalidation training. Managers used an electronic training matrix to see the current position on staff training. Reminders were sent to staff by a central team to remind them when training was due to expire.
- Staff told us that face-to-face training was not always delivered in a timely manner. Courses were often full or did not happen frequently enough.

Assessing and responding to patient risk

- We saw completed Nursing Assessment documentation. Patient risks were assessed at the earliest opportunity and actions identified. Assessments were carried out relating to cognition; communication; breathing; pain; nutrition and hydration; physical function; skin integrity; continence; mobility; sleep disturbances; emotional behaviour, frailty; alcohol and smoking intake; medication and caring responsibilities.
- Risks were reviewed when required and if the patient's circumstances changed in any way, for example, a carer leaving the household or the patient moving house.
- Meetings were held with local GPs to discuss patients with complex needs and those at the end of life.

Staffing levels and caseload

- There were substantial staff shortages in District Nursing services.
- A study carried out on District Nursing staffing in Greater Manchester by NHS England in 2014 identified that District Nursing staff in the Communities Business Group faced a significantly heavier workload than other trusts in the area and staff were shown then to be working well beyond their contracted hours. Tameside and Glossop was shown to be a high outlier on caseload levels. Service quality was seen as markedly lower in Tameside and Glossop Community Nursing than the England average and services were not co-ordinated well. Significant staffing shortfalls were identified by the study. The initial study recommended that staffing should increase by 19% on District Nurses in Tameside and Glossop.
- The trust had since carried out two further, similar, studies using the report author to carry out these studies. The latest study indicated that the nursing staff shortfall in Tameside and Glossop Communities was 66%, equating to 56.91 additional WTE nurses. It was recommended that a further study be carried out in 2016 to determine whether this figure was an aberration.
- England Best Practice Sites, highlighted in the report, show that the caseload per practitioner per day should be 8.25. In Tameside and Glossop, this was 12.39 per day.
- It was not clear whether a further review would be carried out before the service was transferred to Tameside Hospital NHS Foundation Trust. There was an intention to share the outcomes with Tameside and Glossop CCG but no clear intentions to make improvements to the service before staff transferred to another provider from April 2016.
- The trust had determined that in Stockport Community Nursing, a 22% uplift was required, equating to 25.11 additional WTE staff. They required a budget input of £546,400 to enable this. They had arranged a meeting with the CCG, to discuss this.

Requires improvement

Are services safe?

- On the face of it, the studies indicated that the trust was operating Community Nursing with significantly unsafe staffing levels and unsustainably high caseloads.
- District Nurses organised visits on a daily basis and caseloads were unpredictable. Visits could be requested at any time and if a member of staff had a complex and time-consuming visit, other visits were often re-allocated to ensure all patients were visited.
- All the District Nursing staff that we spoke to told us about staffing shortages and having to work extra hours to get the job done. Time off in lieu or overtime was not offered in most instances. Nurses reported that they regularly worked up to an hour extra each day.
- The impact on patients was minimal as staff completed patient visits by working beyond their shift end time. One District Nursing Team told us that they received assistance to deliver morning insulin injections in a timely way from the long-term conditions team.
- There were high levels of sickness (over 9%) and staff absences, such as maternity leave, amongst the District Nursing staff and also high levels of staff turnover (over 15%). Many Band 6 staff had left the service however difficulties in recruiting District Nurses meant that that these Band 6 staff were still to be replaced.
- Staff reported that there were delays in advertising vacant posts.
- The Trust had introduced Band 2 posts into District Nursing services. These posts had a dual role, carrying out admin work and Health Care Assistant work. Staff told us that the assistance with administrative work had freed up a lot of their time and enabled a better service as there was generally someone in the office to receive phone calls, log cases onto the Lorenzo system and make appointments. These posts were not yet in every clinic and the roles were still being embedded with staff picking up the clinical side of their role more slowly than the administrative side. Our observations were that the Band 2 posts were carrying out more than 50% administrative work at the time of inspection.

Managing anticipated risks

- The trust had a Lone Working Policy and staff were able to access this on the intranet.
- Lone working equipment for staff working in the communities had recently been decommissioned and this could impact on the safety of staff working in patients' homes.
- Evening and night staff did not carry out visits alone.
- Risks highlighted during visits were cascaded at team meeting or handovers and details of the risks were put on the Lorenzo system. For example, patients with dogs or tripping hazards.
- There was a major incident plan in place and this was available on the intranet.
- Staff were familiar with the Seasonal or Winter Management Plan and this had been actioned a number of times in adverse weather conditions. In the event of snow, staff made their way to their designated closest clinic and 24/7 District Nursing was able to continue once appointments had been redistributed or re-arranged. Staff ensured that all insulin doses were still given by walking to appointments where necessary and in some outlying areas the Mountain Rescue Services were used to ensure that Nurses got to appointments.

Good

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 health care services as **Good** for Effective

We saw comprehensive care planning in which NICE guidelines and local CQuIN quality innovation were used.

Appropriate guidance was given to stakeholders such as care homes and carers to enable co-ordinated care pathways for patients.

Care plans were reviewed appropriately and discharges facilitated at the earliest opportunity.

There was good evidence of multidisciplinary team working that facilitated patient access and flow, appropriate discharges and helped to prevent hospital admissions or readmissions.

Staff had access to information and were aware of their responsibilities with regard to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Issues were identified with clinical competencies not being transferred between services and organisations, a delay in receiving appropriate training and the receiving of formal supervision.

Numbers of staff appraisals carried out were below target though were increasing or had been booked.

Patient consent was not seen on all patient notes examined.

Detailed findings

Evidence based care and treatment

- Clinicians used a new Nursing Assessment document when assessing patient needs and planning care. The new document had been in use since August 2015 and was linked to local CQuINs (Commissioning for Quality Innovation) on frailty screening and smoking and alcohol intake. For example, if the assessment showed a score higher than 3 for frailty, the patient was referred to their GP for a frailty screening assessment.
- Clinicians followed NICE best practice guidance, examples included, prevention and management of pressure ulcers, type 1 diabetes and urinary incontinence.
- Community based nurses provided guidance and training to care homes and carers regarding NICE guidelines on pressure ulcers for turning and tilting patients to help support best practice in a range of care settings.
- The most commonly used community based care pathways were for the management and promotion of Continence, End of Life care, Diabetes and Wound Care (including pressure ulcers).
- Individualised care plans were made for each patient and the patient was always involved in deciding their care. Care plans were adjusted to meet patient's tolerances and wishes, for example, some patients could not tolerate tight leg bandages and other solutions needed to be sought.

Nutrition and hydration

- Clinicians carried out screening of nutrition and hydration during the Nursing Assessment. Patients could be referred to, for example, the Health Improvement Team if they needed specialist dietary support.
- Diabetic clinic notes examined indicated that in three out of the five sets looked at, there had been no dietary assessment. Two sets of notes showed that the patient's nutrition and hydration needs had been assessed and the patient had been given advice on meal times and what to eat and drink to improve their condition.

Technology and telemedicine

- Administrative staff had an electronic booking system and, as such, were aware when patients used more than one community service. They would be guided by a clinician but were able to book multiple appointments on the same day, if available.

Good

Are services effective?

- District Nursing staff had trialled electronic devices in the field to track appointments and make patient notes but these were found to be ineffective as it was awkward to achieve Wi-Fi access when required so they have continued with manual records and note-taking.
- District Nurses all had camera phones in order that they are able to photograph wounds at every visit so that visible progress of the healing process could be accurately monitored.
- Lone working devices used by clinicians working in patient's homes had been de-commissioned by the trust because they said that they were not being used. Rather than make their use mandatory the devices had been replaced with mobile phones.
- Self-operated syringe drivers had been given to patients in the past but there were none at the time of the inspection[FA1]. Syringe drivers were considered for those patients with persistent nausea or vomiting; bowel obstructions; swallowing difficulties; severe weakness; end of life care requirements; confusion or delirium and poor absorption. Self-operated syringe drivers were only offered where the patient was not suffering confusion or delirium or severe weakness, were elderly or vulnerable and could be trained to use the equipment safely and correctly. Patients were rarely considered suitable for self-operated drivers.
- The Orthotics Team at Ashton Primary Care Centre had on-site equipment to enable the taking of foot casts and production of an orthotic shoe insert in a short time. Orthotics could be produced in around an hour if necessary. They carried out some private work on behalf of the trust, for example, footballers were referred for orthotic inserts. The system used, was such that it was in use worldwide and a patient's electronic foot cast was available on the system and a replacement orthotic could be reproduced elsewhere.

Patient outcomes

- A review of the Care Plan was made at every visit or patient clinic appointment, to determine whether adjustments needed to be made. If results were not as expected this was escalated and discussed at "team time".
- Care Plan reviews and amendments were dated.
- Patient outcomes were discussed at team time and we saw a discussion about a patient outcome and discharge at a District Nurse Team Time.
- Staff facilitated emergency hospital admissions where they found a deterioration in the patient's condition that would warrant this, for example, a patient whose blood sugars had dropped to dangerously low levels was given glucose tablets by the nurse who also called an ambulance.
- Services carried out clinical and other audits to improve patient care and outcomes.
- District Nurses carried out documentation and catheter audits on a monthly basis and medicines, pressure ulcers, falls and venous thromboembolism (VTE) safety thermometer surveys for harm-free care[FA2][JP3]. Audit results had improved since the introduction of Nursing Assessment Forms. A medication audit was carried out on the last Wednesday of every month. Safety Thermometer audit results were input electronically for ease of comparison. Results were disseminated at Team Time and reasons for any drop in results were discussed.
- Bramhall health Centre District Nurses had taken part in a mouth care oral hygiene audit for patients in their last days of life and a telephone audit for monitoring messages from patients or carers.

Competent staff

- The Senior Management Team told us that a lot of work had been carried out in relation to staff competencies; clinical competencies were written and a "Clinical Competencies Passport" was issued to each staff member. There was a launch date ("Nursing Community Day") for all staff involved. We were told that staff competencies gained elsewhere were added to the passports to enable staff to carry out relevant procedures.
- Nurses told us that competencies gained elsewhere were not added to their "passports" and that they must be regained when they move into Community Healthcare. This did not meet patient needs and put added pressure on colleagues.
- They gave examples of where this had happened, for example, a nurse who was previously a trainer in IV skills moved into the Directorate and was not allowed to manage IV lines until they had attended the relevant training and had competencies assessed.
- Nurses also highlighted disparities in training offered in Stockport Community Healthcare and Tameside and Tameside and Glossop Community Healthcare. For

example, a Band 3 Nurse in the Tameside area would receive syringe driver training but not in the Stockport area. Doppler use training was given in Stockport but not in Tameside.

- Nurses told us that required training courses were not held frequently enough and were often full or cancelled, for example, a Nurse who started in June 2015 had still not received IV training, that consists of a SNAP test and practical skills test, despite having being booked on the course twice. Another Nurse had worked at the trust for almost two years and was still unable to carry out manual handling, as there had been no spaces on the required training course.
- We were given an example of a Nursing Team in the Stockport area where only three of eight team members could carry out all activities, this was affecting the distribution of appointments and individual workloads.
- Staff told us that they did not receive any formal clinical supervision. A clinician at Ashton Primary Care Centre had not seen their manager for over a year. District Nurses were able to discuss clinical matters in their lunchtime meetings in a forum environment.
- At September 2015, the numbers of staff receiving a 12-monthly appraisal was falling well below the trust target of 95% at 73.40% across the Communities Business Group. For example, in Stockport District Nursing only 41.84% of staff had received an appraisal at this date. Some Community Adult staff had worked for the trust for over two years and had only just had their first appraisal.

Multidisciplinary working and coordinated care pathways

- Band 6 Nurses met on a monthly basis to plan how care was delivered and meet any gaps in the service. There was close working with the Palliative Care Team, Long-term Conditions Team, Diabetes Team, Tissue Viability Nurses, Continence Nurses and Care Homes. They followed the Gold Standards Framework for End of Life patients and met with GPs once a month.
- District Nurses worked very closely with the Palliative Care Team and Macmillan Nurses. They often conducted joint visits to end-of-life patients where the District Nurses operated the syringe drivers. They also went to the patient's home together where the patient had died, in order to see the family and destroy any controlled drugs on the premises.
- District Nursing teams worked closely with local GPs and care homes to facilitate co-ordinated care pathways.
- Tissue Viability Nurses worked with the District Nurses and Diabetes clinicians and put care plans in place to treat chronic wounds. Information was shared between the relevant teams.
- Multidisciplinary teams involving District Nurses, the Diabetes Team and Local Authority Carers worked hard to encourage diabetic patients to self-administer insulin. They were trained in their own home. Most training successfully enabled the patient to administer their own insulin and those requiring daily injections from District Nurses were mainly the elderly, people living with dementia and people with learning disabilities.
- Notes from all multidisciplinary team members who have contact with the patient were kept in the patient notes, including details of telephone calls to GPs, for example.
- At Crickets Lane Clinic, the Long-term Conditions Team assisted the District Nurses in delivering the morning insulin doses in a timely manner as the caseload was high (45 insulin injections per day).
- The Orthotics Team demonstrated good multidisciplinary team working with the MSK and MSK Physiotherapy Teams. Back-to-back appointments were arranged when possible when the patient needed to use more than one service.

Referral, transfer, discharge and transition

- Administrative staff were responsible for logging referrals onto the electronic booking system, whether these be referrals from the hospitals, GPs or self-referrals. They reported that there was adequate information on the referral sheets to enable triaging of the patient.
- District Nurses were able to take referrals in any format, such as by telephone, fax or face-to-face. In clinics a referral form was used. Administrative staff assisted patients in completing self-referral forms.
- Out of hours District Nurses had an answerphone to take referral information and visit requests.
- District Nurses would carry out extra visits to support discharges.
- District Nurses worked with local GPs to meet the care and treatment needs of the patient when they had been discharged from an acute setting.
- The Community Assertive In reach Team (CAIR) were based in the acute setting but hosted by the Community

Good

Are services effective?

Healthcare Business Group. They were responsible for facilitating appropriate discharges and aversion of hospital admissions or early hospital discharge through assessment and treatment of individuals. They supported individuals to remain in community settings, in their own home, residential or nursing homes. The CAIR pilot had helped to support a rapid discharge from an acute setting. They had prevented a number of acute admissions and worked closely with District Nurses

- The IRIS Team prevented emergency admissions to hospitals and residential care. They provided integrated care from a joint health and social care assessment, supporting primary care and community services to prevent deterioration, avert crisis and maintain clients in the community during the sub-acute phase of illness.

Access to information

- Staff had access to the trust intranet and showed us how they were able to access policies, procedures and clinical guidelines.
- Patient notes were paper and were generally stored within the clinic area or at the District Nurses' base. As such, there was no evidence of appointments requiring cancellation due to information not being available to the clinician.
- The NHS Choices website generally holds up to date information on types of clinics and referral to treatment times for each service. Although the website holds location details of most of the Community clinics, there were no details on opening times, facilities or services offered at each clinic to enable patients to make an informed choice about their care and treatment.
- Appointment letters that we saw were clear and informative and told patients what to do if the appointment was not convenient and needed to be changed.
- In a survey carried out by Tameside and Glossop MSK Physiotherapy in May 2015, 89% of patients said that the letter they were sent prior to their first appointment was excellent or very good.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- TheMental Capacity Act(MCA) is in place to protect and empower individuals who may lack themental capacityto make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. The Deprivation of Liberty Safeguards (DoLS) aim to protect people who lack mental capacity, but who need to be deprived of liberty so they can be given care and treatment in a hospital or care home. Training on both was available to clinical staff.
- Staff were aware of their responsibilities and able to access guidance on the trust intranet.
- Administrative staff did not receive training on the Mental Capacity Act or living with dementia.
- We examined 16 sets of patient records across District Nursing (held in the clinic and in the patient's home), a Diabetes clinic and leg ulcer clinic. The patient's signature of consent was seen on all the records relating to leg ulcers and all the District Nursing records in patients' homes but only one of the records held at the District Nursing base. Of the five diabetic clinic notes checked, a patient consent signature was not present.
- District Nurses obtained separate consent from the patient for photographing wounds.
- If a patient did not wish to comply with the recommended care plan, they were asked to sign their non-compliance to indicate that this was their wish and agree that they had been made aware of the risks.

Good

Are services caring?

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

Summary

We rated community adult health care services as **Good** for Caring.

Kind, caring and compassionate staff delivered community adult services. They were observed to be polite, friendly, helpful and made efforts to alleviate patient fears and anxieties .

Staff treated patients with dignity and respect and explained treatment to patients. Patients were encouraged to agree treatment aims and to be actively involved in their care.

Detailed findings

Compassionate care

- We observed that staff were friendly and supportive to patients and that reception staff were knowledgeable and able to help patients with queries.
- The electronic booking system was able to send automated text messages to patients to request Friends and Family test feedback and there were use of I-pads to complete the survey in treatment rooms.
- A patient satisfaction survey carried out in Tameside and Glossop podiatry services in June 2015 was very positive. 100% of patients indicated that they had been treated with dignity and respect and that podiatrists were friendly and easy to talk to. 99% felt that that they had been given enough time and opportunity to ask questions during their appointment. The survey was carried out over 10 clinic sites and 100 responses were received.
- In a similar survey carried out in Tameside and Glossop MSK Physiotherapy in May 2015 almost all patients said that they had received excellent explanations about assessment and treatment; that they were listened to, felt involved with their treatment plan and were given the opportunity to ask questions. In this instance 300 questionnaires had been sent out or handed to patients and 133 (44.3%) had been returned.
- In clinics that we visited seating was far enough away from the reception desk to allow for patient privacy and confidentiality.
- Also in Hazel Grove clinic there was a potential issue with privacy and dignity in the podiatry room. This had a sign on the door that said that because of the nature of the building and clinic, there may be occasions where a patient needs to share a treatment room with another patient and clinician and if this causes concern, they should speak to a clinician.
- Elsewhere, we observed that consultations and examinations took place in closed examination rooms that were soundproof and had appropriate signage on the door, to indicate when the room was in use

Understanding and involvement of patients and those close to them

- We saw that District Nurses plan care with patients and their carers and relatives and often with care home staff.
- Patients that we spoke to under the care of District Nurses all said that they were involved in making decisions about their care, that options were given and explained and they had the opportunity to ask questions and discuss everything.
- There were no issues in patients being accompanied into the treatment room and supported during their treatment. We observed the treatment of a patient living with vascular dementia who had brought their husband with them. The patient was treated with dignity and respect throughout and put at ease by the nurse who explained exactly what was happening and why and what had happened when they had attended previously. Explanations of what the patient needed to do regarding self-care at home were given to the patient's husband and he was asked what support he might require to care for his wife.

Emotional support

- Staff, including Admin staff, were encouraged to attend "Sage and Thyme" training delivered by Macmillan Nurses. The training covered enhanced communication skills and was designed to train all grades of staff how to listen and respond to patients or carers who are distressed or concerned.

Good

Are services caring?

- We saw that every effort was made to promote self-care in patients, for example, patients were trained to self-administer insulin injections and use syringe drivers and diabetes patients were also given dietary advice and coaching to stabilise their condition.
- District Nurses told us that they would spend as long as necessary with a patient and their family when providing palliative care and were supported by the Palliative Care Team and Macmillan Nurses.
- Tameside and Glossop MSK Physiotherapy patients reported in a survey that they felt confident in managing their symptoms when they had been discharged and that they felt that their treatment met their expectations.

Good

Are services responsive to people's needs?

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

Summary

We rated community adult health care services as **Good** for Responsive.

There was a lack of access to information leaflets in different languages and cards in different languages to aide communication with Community Nurses.

Buildings were accessible to wheelchair users though some doors made mobility through the building difficult.

There was no access to information in braille or large print for blind or partially-sighted patients.

Patients' needs were discussed with the patient, stakeholders and carers to ensure the needs of the patient were met.

Staff were trained in equality and diversity and there were "Dignity Champions" in clinics.

There was timely access to appointments and treatment and urgent cases could be seen on the same day by District Nursing staff.

Complaints were dealt with in line with trust policy though staff did not always receive feedback about complaints and a survey indicated that only half of patients knew how to make a complaint.

Detailed findings

Planning and delivering services which meet people's needs

- Complex needs were discussed between services and there was a multidisciplinary approach to care planning and treatment.
- Stakeholders, such as GPs, Care Homes, Social services and Carers were involved in planning and delivering services to meet the patient's needs.
- Treatment plans were discussed with patients during visits and clinic appointments including how often they would need to be seen and how long the period of treatment may take.
- Patients were invited to share their experiences and one patient was asked to become a patient representative on future projects.
- Assessed staffing levels did not appear to take account of the demographics of the local population, for example, the number of care homes in the area.

Equality and diversity

- Staff received mandatory equality and diversity training on an annual basis.
- There were "Dignity Champions" within clinics and health centres who had received the accredited Daisy training. We were shown the file of dignity information and assessments kept by one of the Dignity Champions.
- There was a lack of access to information leaflets in different languages. There were leaflets on domestic violence available in Urdu.
- Interpreters were used when required and were booked in advance through the LIP Service based at Tameside Hospital.
- Language Line was available for use at short notice.
- We were told that interpreters sometimes do not turn up to booked appointments.
- A District Nurse told us about a problem she had had that day when she was unable to communicate with a patient and could not determine the language and dialect they spoke to enable the booking of an interpreter. As a result, they were unable to obtain consent and treat the patient. The District Nursing staff had no access to language cards so the patient could point to the language they spoke.

Meeting the needs of people in vulnerable circumstances

- Patients' needs and wishes were recorded in their notes.
- Patients living with dementia or learning difficulties were identified and care provided to meet their needs and liaise with those people who helped to care for them.
- Health centres were accessible to wheelchair users.
- Some doors were heavy to open and posed a problem to patients with mobility issues. We saw that, even in Ashton Primary Care Centre, that is a new, purpose built building, doors did not open automatically. On one of

Good

Are services responsive to people's needs?

the upper floors a wheelchair user was unable to open a door that opened towards them and assistance by Reception staff had to be given to facilitate the patient moving through the building.
- Some health centres (but not all) had "drop-down" areas at the Reception Desk to facilitate wheelchair users.
- There were hearing loops for the deaf but nothing for blind or partially sighted service users, such as leaflets in braille or large-print.

Access to the right care at the right time

- We saw that there were procedures in place within District Nursing to ensure that the patient was seen by the right nurse, with the right skills at the right time and that more complex cases were referred to nurses with the appropriate skills.
- Cases were triaged by a SPOC (single point of contact) Nurse and allocated at the earliest opportunity. However, high caseloads and not all nurses being fully competent meant that less urgent visits were often delayed.
- We saw that patient access and flow was good with people able to access the services they required in a timely way and with a level of choice.
- District Nurses were able to carry out urgent referral visits on the same day where required.
- Sexual Health clinics offered a walk-in service.
- Some clinics ran on a Saturday, for example, Sexual Health and District Nursing Treatment Rooms for wound care.
- At Ann Street Clinic in Tameside and Glossop, patients were generally able to book into their clinic of choice with three days' notice.
- There were few cancellations or rescheduling of clinics. There was access to Bank Staff to cover clinics in the event of staff absence, or if this was unfeasible, District Nurses could cover some clinics or treatment rooms.
- Trust figures show that, in October 2015, 59.6% of Community patients in Stockport waited less than four weeks for an appointment. In the same month in the Tameside and Glossop Communities Services 68.8% of patients waited less than four weeks for an appointment.

Learning from complaints and concerns

- Complaints were handled in line with trust policy and were resolved locally wherever possible.
- Staff were aware of and had access to formal complaint leaflets and initially referred those patients who wished to complain to the Patient Advice and Liaison service (PALS). PALS leaflets were available in clinics.
- Staff were aware of the trust complaints policy and could access this via the trust intranet.
- We were unable to see any written complaints and subsequent responses as they were held off site at trust headquarters.
- A District Nursing manager told us that they receive very few complaints and the number of formal complaints is very low. They reported that complaints are usually about a breakdown in communication about the time or date of an expected visit.
- Staff said that they received little feedback on complaints that had been made.
- On a patient satisfaction survey carried out by Tameside and Glossop Podiatry services, only 50% of patients said that they would know how to make a complaint.

Requires improvement

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 Healthcare services as **Requires Improvement** for Well-led

The Communities Business Group Board report directly to the Stockport NHS Foundation Trust Management Board.

There was no staff retention or recruitment plan in place, despite a service review identifying a shortage of District Nursing staff and a number of District Nurses (especially at Band 6 level) leaving the service.

Band 6 and 7 staff were supportive of their teams and led by example. Team members were supportive of each other, covered the work of absentees and worked extra hours to get the job done.

However there was a communication issue between staff above Band 7 level and those below. For example, staff in Tameside and Glossop Community Adults told us that they did not feel that they had been fully informed about their transition to Tameside Hospital NHS Foundation Trust and their concerns about working in an integrated team had not been addressed. The management board was unaware that the introduction of a clinical competencies passport was not working as intended.

Members of the trust and Communities Business Group senior management team were not visible in community bases. Most said that they did not feel part of the trust as a whole and the Stockport, and Tameside, and Glossop Community Adult staff still felt separate from each other and the services were run as separate entities.

The trust had introduced a number of learning programmes for Community staff but we found that there were issues with staff finding the time to carry out this additional learning. The trust had developed a Specialist Practitioner course for Band 5 nurses, to enable them to become Band 6 staff. However, only four staff started this course in September 2015. There were issues with delays in staff being offered training to enable them to carry out all the required activities, for example, a Nurse who started in June 2015 had still not received IV training despite having being booked on the course twice. Another Nurse had worked at the Trust for almost two years and was still unable to carry out manual handling, as there was no space on the course.

There were high sickness absence and staff turnover rates in the Communities Business Group. At September 2015 the sickness absence rate across the Communities Business Group was at 5.58% against a trust target of less than 4%. There were high levels of sickness (over 9%) and staff absences, such as maternity leave, amongst the District Nursing staff and also high levels of staff turnover (over 15%).

Detailed findings

Service vision and strategy

- Most staff were aware of the trust vision and values though we did not see these displayed in clinics.
- Most policies, procedures and strategies were generic across the two Adult Community Services but had taken some time to change and embed. However, the two services had not been integrated and there were disparities in the way the services were led at a local level, for example, the shift working patterns for District Nurses.
- We questioned why there had not been more integration and were told that the trust had always known it was a three-year contract when Tameside and Glossop came into the trust.
- When Stockport Community Healthcare were integrated into the trust they took on Tameside and Glossop's procedures but the two services still did not work in the same way. For example, in Stockport, some staff preferred to work condensed hours over 4 days but this was not seen as being patient-centred and meeting the needs of the service as patients did not want a visit at 7:30 am and would prefer a visit between 9am and 11am. In some District Nursing services in Tameside and Glossop four-day working had been adopted.

Requires improvement

Are services well-led?

- At a higher level, the Trust were participating in the "Healthier Together" programme of change for Greater Manchester that will change the way that health, social and community care is delivered across the Greater Manchester region.
- At the time of our inspection, there were plans to transfer the majority of community healthcare services in Tameside and Glossop to Tameside Hospital NHS Foundation Trust with effect from 1 April 2016. Adult community services were to be integrated and work in multidisciplinary teams with partners in social care, primary care, the local authority and the third sector to become "Care Together" in the Tameside region. The long-term plans were for "Care Together" to become a stand-alone organisation. Stockport adult community services were to remain under the control of Stockport NHS Foundation Trust for the time being but will also move forward with a similar transformation project known as "Stockport Together".
- We noted that the service had no current strategy for staff retention or for addressing staff shortages and sickness, especially in the District Nursing service, despite several reviews of the service staffing having been carried out since 2014. The trust did have a meeting arranged with Stockport CCG to discuss the outcome of the latest staffing review.

Governance, risk management and quality measurement

- There was a risk register for Community Healthcare across the trust with dates identified, actions, completed and review dates. The register showed that potentially unsafe staffing levels in District Nursing in Tameside was identified in November 2014 and the management plan was to review and redistribute staff; prioritise visits to those in greatest need; review bank staff available and manage staff absence.
- The register also indicated that a reduced staffing level in Stockport Community Adults was identified in December 2014 and similar action points were made with an additional clause to maximise recruitment.
- The risk register did not reflect all the risks that we identified and highlighted during our inspection and there was no clarity on leadership having adequate control of risk management.
- Community Health had a Quality and Performance Board and they produced a monthly action log for quality improvement. The action log for October 2015 highlighted actions to be taken on pressure ulcer recording; updating the risk register; taking information from exit interviews; response rates for Friends and Family tests and dealing with complaints, for example. Target dates for actions were given, although there were no completion dates on the log. There was a "RAG" (Red, Amber, Green) rating given for each action, all of which were shown to be Amber or Red.

Leadership of this service

- A Director and Deputy Director of Community Healthcare and a Head of Adults for Tameside and Glossop and a Head of Adults for Stockport led the Community Adults Healthcare Service. The Deputy Director had a background as a Head of Long Term Conditions and Lead Nurse in Community Health.
- At local level, we saw that Band 6 and 7 Nurses were supportive of their teams and led by example. Feedback from Nurses and other healthcare professionals reflected this.
- We saw that there was a disconnect between staff above Band 7 and staff below. Staff reported that they never saw the Director of Nursing from the trust and did not feel part of the NHS Trust but rather part of an individual Community Healthcare Service.
- Below Band 6 level, there was no supervision or team meetings and no formal policy on supervision. Daily "team time" meetings held at lunchtime were documented and we saw these records.
- Lack of communication between the Senior Management Team and staff at lower levels was highlighted by the fact that they had no idea that the clinical competency passport scheme was not working and that competencies attained in different trusts or in an acute setting were not being transferred.
- A staff member at Ashton Primary Care Centre told us that they had not seen their manager for over a year, had received no clinical supervision and had received little information about their transfer to Tameside Hospital NHS Foundation Trust.
- The Communities Group had a Leadership Academy for staff to undertake leadership training both locally, across the north west and nationally.

Culture within this service

- District Nursing staff reported that they had been threatened with disciplinary action if insulin doses were not delivered by 8:30am or by 4:00 pm for afternoon

doses. They said that this was not possible, where, for example, they may have 14 doses to deliver. They gave an example of a Band 5 Nurse who had to visit five localities with two to three visits in each locality. This may be within a 30-mile radius.

- There were high sickness absence levels in the Community Healthcare Service. In 2015, 812 FTE days were lost to stress-related absences across Bands 2-6 with the highest number recorded in Band 5 Nurses.
- In 2015, 892 FTE days were lost where no reason for sickness absence was given and again, the highest number was across Band 5 practitioners.
- The highest numbers of long-term absences were stress-related absences or reason unknown and 76% of long-term absences were in Band 5 staff.
- At September 2015 the sickness absence rate across the Communities Business Group was at 5.58% against a trust target of less than 4%. In the District Nursing Services this figure was over 9%.
- Staff turnover was running at 15.86% in September 2015 against a trust target of less than 10%.
- We observed good team rapport in individual teams and staff were supportive of each other. Managers reported that staff would "go the extra mile" to ensure that patient needs were met. And a Band 7 manager said that they could not speak more highly about the teams that they manage. We observed that District Nurses worked beyond their shift end to ensure that their visits were completed and we that this was commonplace.
- The District Nursing GPS Lone Worker Safety System had been decommissioned following a cost risk assessment. We were told that staff were not using it. This system enabled an alarm to be activated discreetly, GPS tracking of the staff member location and two-way audio functionality. Some Nurses were sharing mobile phones but they now had one each and were expected to use them if them if they got into danger or need to call for assistance. The IPM (Lorenzo) system enabled the flagging of risks so that shared visits could be arranged and the GP out-of-hours service offered a chaperone service for night staff.
- It is not clear why staff were not told that they must use their lone worker devices to avoid breaching the Lone Worker Policy. Mobile phones are not lone worker devices and staff safety could be put at risk by the withdrawal of the devices.
- A number of Band 6 nurses had left the service, for example. Nine Band 6 Nurses had left Community Adults in the Stockport area. A focus group during the inspection for Nurses of Band 6 and below reported that exit interviews were not offered to staff, despite some staff wanting them. Band 7 staff reported that exit interviews were no longer offered and there was no staff retention plan in place.

Public engagement

- Responders to the annual "How did we do today?" census were asked to comment on things that the Communities Services could do better.
- MSK Physiotherapy Tameside and Glossop, based at Ashton Primary Care Centre and Shire Hill Hospital carried out a comprehensive patient survey in May 2015 seeking patient views of the service. The survey was positive with patients saying the best things about the services were the advice and information given and the Physiotherapists. The majority of patients said that nothing was the worst thing about the service whilst 23% said the waiting time in clinic was the worst thing.
- A similar survey was carried out with Tameside and Glossop Podiatry patients. This too was a positive survey.
- Patients with an experience to share were invited to the Community Business Group Board meetings where they told the board about their experiences as a community patient and what could be done better. A follow-up document was drawn up detailing what the outcome was, what was learnt and which teams this learning was shared with. The age range of these patients was between 15 and 89. One patient was asked to be a patient representative on other pieces of work being carried out.
- Reviews of patient letters enabled learning from patient experiences.
- The Communities Business Group held an annual "How Did We Do Today?" census to gauge patient views on the services in Communities. The second such census was held in May 2015. There were 177 responses in Stockport, 338 in Tameside and 82 in Glossop. 96% of responders in Stockport and 98% of responders in Tameside and Glossop said that they would be likely or extremely likely to recommend the services to friends or family.

Staff engagement

- Last year's business group action plan, arising from the staff survey results, focussed on appraisals and staff

health and well-being. The Chief Executive had put on events and the Community Health Director carried out "Choc and Chat" events where they visited clinics to speak to staff directly.

- Staff said that they usually did not have time to attend events elsewhere as they put the patients' appointments first.
- Senior managers reported that they were disappointed in the percentage numbers of staff who had completed the Staff Survey. We asked 10 nurses in a Focus Group how many had completed the survey. About half had done so and some had not heard of the staff survey. Staff elsewhere in Community Adults reported that they had never received any feedback on the outcomes of the staff survey. Band 7 nurses reported that they had received little feedback on the survey and that outcomes had not been broken down so that issues could be discussed at team level.
- Community Adults staff in Tameside and Glossop below Band 7 level widely reported that they had received little information about their transition to Tameside Hospital NHS Foundation Trust and there had been little staff engagement. They raised a concern about the transition and working in an integrated multidisciplinary team, namely that, in outlying areas that cross into Derbyshire, District Nursing teams follow GP boundaries. Local Authority staff though, would not work outside the Tameside boundaries so they were concerned about failings in outlying areas. We were not assured that their concerns had been addressed.
- Tameside Hospital NHS Foundation Trust had carried out listening events for transitioning staff but staff said they had not had the time, and it was not convenient, to attend these events. Stockport NHS Foundation Trust had produced an FAQ Bulletin about the transition.
- The Communities Business Group for staff in District Nursing, Intermediate Care and Diabetes, had held listening events. These were events where the Director, Deputy Director and members of the senior management team visited teams who had identified issues and required senior support. We saw details of these events that had been held since August 2015. The attendance levels of these meetings is not known.
- Compliment letters were shared with staff at lunchtime meetings.

Innovation, improvement and sustainability

- The Communities Business Group had developed the "Daisy" Project, which was a Dignity and Respect accreditation programme across community services and other external providers and partners. The Dignity Matron oversaw it. The accreditation was a quality marker for organisations to demonstrate that they deliver a service that has dignity and respect embedded into it. The accreditation programme was funded by services that have signed up. They included a local college; 18 care homes; the Go-To-Doc service; Mastercall in Stockport and 435 staff were also accredited. Accreditations were re-validated every two years and dignity award ceremonies were held twice a year. Shire Hill Hospital had received a Dementia-Plus Dignity Award. The Dignity Matron held "Dignity Days" in community locations. We witnessed a Dignity Day in Ashton Primary Care Centre. Patients were informed about the accreditation, how they could expect to be treated and asked to give their opinion about what they thought dignity was.
- The CAIR (Community Assertive In reach Team) pilot had helped to support a rapid discharge from an acute setting. They had prevented a number of acute admissions and worked closely with District Nurses.
- A number of Band 5 and Band 6 staff had been accepted to undertake the Specialist Practitioner Degree course. The trust had also developed a Community Development Programme to support Band 5 staff who had not been accepted on the Specialist Practitioner Degree course to improve their chance of being successful in the future. There were shortages in the numbers of band 6 staff and these two programs were developed to improve the skills of existing band 6 staff and support band 5 staff to progress to a band 6 role.
- The Communities Business Group had supported staff to undertake an MSc in Dementia.
- The Business Group ran an interactive training programme for staff called "Proud to be a 6C Professional". The course accredited staff in delivering care, compassion, competence, communication, courage and commitment.