Cambridgeshire Community Services NHS Trust

RYV

Community health services for adults

Quality Report

Head Quarters
Respite House
Orwell sexual health clinic
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Date of inspection visit: 28 - 30 May and 6 June 2014
Date of publication: 02/07/2014

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Community health services for adults are provided by Cambridgeshire Community Services NHS Trust in various locations, including community hospitals, health centres and in people's homes.

We visited three community hospitals, six health centres, and went on home visits with four District nursing teams. We spoke with 52 people who used the service, or their relatives, and received comments from people who had attended a listening event prior to the inspection. We spoke with 68 staff including: doctors, district nurses, specialist nurses, occupational therapists, physiotherapists, podiatrists, community matrons, healthcare assistants, therapy assistants, and reception and administration staff. We spoke with two volunteer staff.

We inspected the regulated activities:

- Accommodation for persons who require treatment for substance misuse
- Diagnostic and screening procedures
- Family Planning
- Nursing care
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

The community nursing services in Peterborough and Cambridgeshire were last inspected by CQC in December 2013. We found concerns in relation to staffing levels and risk management and told the Trust to take action. At this inspection we found the Trust was making progress with achieving sufficient staffing levels and was now meeting the essential standard in relation to risk management.

People who used the service and staff were protected from abuse and avoidable harm. There were effective systems in place for reporting safety incidents, including allegations of abuse. Staff knew how to report safety incidents. Although there were systems to pass on the outcome and learning from incidents, some staff said this did not always happen.

There were suitable arrangements for the prevention and control of infection, maintenance of the environment and equipment, and the safe management of medicines. People's personal and confidential information was stored securely. However, there was a low uptake of staff attending training in infection control and information governance. The Trust had identified areas where there were risks related to staffing levels and recruitment and there were plans in place to address these risks. There were appropriate arrangements for lone working.

People who used the service received effective care and treatment that achieved good outcomes, promoted a good quality of life, and was generally based on the best available evidence. Staff were suitably qualified and competent to carry out their roles safely and effectively in line with best practice. Staff were encouraged and supported to access training appropriate to their roles. However, staff attendance at some training did not meet the Trust's targets, and some staff felt their opportunities to progress professionally were limited. There was effective multi-disciplinary working within the organisation and with other health and social care providers.

People we spoke with who used the service were positive about the way they were treated by staff. People said they were treated with compassion and respect. We saw staff ensuring that people's dignity and privacy were upheld. People were mostly involved in making decisions about their care and treatment. We saw that people's individual preferences, culture and background were respected and taken into account when planning and delivering care. People were encouraged and supported to manage their own care where possible and to maintain their independence. People had appropriate emotional support and were helped to keep in touch with their family and friends.

The Trust delivered appropriate services to meet the needs of different people. People were able to have their care and treatment close to home. People had access to the right care at the right time, including urgent care. People were encouraged at a local level to provide feedback or make a complaint about their care. Information about how to do this and about the action taken by the Trust in response to feedback was not always prominently displayed.

The Trust's vision and strategy for delivering high quality care was referred to on their website and in their

Summary of findings

communications to staff. However, we did not see information about the Trust's vision, values or strategy prominently displayed in the community hospitals or clinics we visited. This meant the Trust's vision and strategy may not be accessible to or understood by all staff and people who use the service. Most staff we spoke with said they felt respected, valued and supported by their managers. They were committed to providing good quality care and were proud of their work.

Summary of findings

Background to the service

Cambridgeshire Community Services NHS Trust provides a range of community health services for adults. The Trust operates in Cambridgeshire, Peterborough, Luton and Suffolk.

Community health services for adults are provided in four community hospitals, numerous clinics and health centres, and also from GP surgeries. Services provided include: District and community nursing; community matrons; therapies and rehabilitation; outpatient clinics for podiatry, people with diabetes, dietetics, musculoskeletal disorders; sexual health and reproductive health services; drug and alcohol services.

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Director of Quality and Commissioning (Medical and Dental), Health Education England

Team Leader: Ros Johnson, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a nurse practitioner, an occupational therapist, a District Nurse, and an expert by experience who has personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

We inspected the Trust as part of our comprehensive Wave 2 pilot community health services inspection programme. The focus of wave 2 is on large, complex organisations which provide a range of NHS community services to a local population.

How we carried out this inspection

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 announced visits on 28, 29 and 30 May 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, therapists and healthcare assistants. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 6 June 2014.

We visited three community hospitals, six health centres, and went on home visits with four District Nursing teams.

We spoke with 52 people who used the service, or their relatives, and received comments from people who had attended a listening event prior to the inspection. We spoke with 68 staff including: doctors, District Nurses, specialist nurses, occupational therapists, physiotherapists, podiatrists, community matrons, healthcare assistants, therapy assistants and reception and administration staff. We spoke with two volunteer staff.

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?

Summary of findings

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

What people who use the provider say

The majority of people we spoke with were positive about the care and treatment they received. People said they felt safe using the service and they were treated with kindness and compassion by staff.

Good practice

Our inspection team highlighted the following areas of good practice:

Through effective and creative multidisciplinary working, drug and alcohol services in Luton provided opportunities and support for people to develop their recovery pathways.

Physio Direct provided an effective service that promoted self-management whenever possible for people who used it. Assessments were comprehensive and were in line with nationally recognised guidance and current good practice. Positive changes were made to the service following feedback from people using it.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The provider must continue to develop effective recruitment, caseload management, and staff support strategies so as to ensure satisfactory staffing levels in the district and community nursing teams.

Action the provider SHOULD take to improve

- The provider should address the low rates of staff attendance at information governance and infection prevention and control training.

Action the provider COULD take to improve

- The provider could improve the environment of the apartments used for rehabilitation of people who used the service so as to promote their wellbeing.
- The provider could review the use of curtains in treatment bays at some outpatient's clinics, so as to improve privacy and confidentiality.

Cambridgeshire Community Services NHS Trust

Community health services for adultsCommunity health services for adults

Detailed findings from this inspection

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

Requires Improvement

Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

Summary

People who used the service and staff were protected from abuse and avoidable harm. People who used the service told us they felt safe. There were appropriate lone working arrangements in place to reduce the risks to staff. There were effective systems in place for reporting safety incidents, including allegations of abuse. Staff we spoke with knew how and what to report as safety incidents. Although there were systems to pass on the outcome and learning from incidents, some staff said this did not always happen.

There were suitable arrangements for the prevention and control of infection, maintenance of the environment and equipment, and the safe management of medicines. People's personal and confidential information was stored securely. However, there was a low uptake of staff attending training in information governance. This meant that staff may lack awareness of how to ensure personal information remained confidential. The service was also not consistently meeting Trust targets for staff attending core areas of training such as safeguarding and infection prevention and control.

At our previous inspection of the Trust in February 2014 we found inadequate staffing arrangements in the community nursing services in Cambridgeshire and Peterborough. The Trust sent us a report on how they intended to achieve compliance by March 2015. At this inspection we found that progress was being made. The Trust had put in place a number of initiatives to increase staffing numbers, review caseloads and streamline processes. Staffing levels were still low, but risks were being closely monitored and managed.

Requires Improvement

Are Community health services for adults safe?

Detailed findings

Incidents, reporting and learning

The Trust had not reported any never events in the twelve months prior to our inspection. Never events are classified as such because they are so serious that they should never happen.

There were effective and embedded arrangements for reporting safety incidents and allegations of, or actual, abuse. Staff could explain how to report incidents and described a range of what they would report. Examples included poor care of patients leading to neglect, unsafe staffing levels, medication errors, and faulty equipment. A staff nurse told us that they reported incidents through the on-line system and these went automatically to their line manager and then on to other relevant area managers. They said that staff at all levels could do this including healthcare assistants. Incidents were investigated and changes to practice were made as a result. They gave an example of a pharmacy delivery box that went missing for a couple of days. This went through the incident reporting system and a new system was put in place to make sure it couldn't happen again.

We spoke with people who used the outpatient services at three community hospitals and they all told us the service was safe. One said, "I am very happy with my local hospital. I have always felt safe and looked after". Another person told us they had used the service for many years and had always felt safe. We spoke with three people who used the drug and alcohol services in Luton. They told us they felt safe.

The Trust had reported 255 serious incidents between April 2013 and March 2014. 168 (68%) of these incidents had occurred in patients' homes and were mostly pressure ulcers grade three or four. There was a nationally recognised grading system in use for pressure ulcers. Grades three and four are the most severe types of pressure ulcer. A root cause analysis investigation was carried out for all grade three or four pressure ulcers. This was to establish the cause, to assess what preventative action could have been taken, and to determine future action to reduce the risk of recurrence.

There was an increase in 2013 in the reported number of patients who had developed a pressure ulcer. The Trust had responded by arranging training about pressure area care that was mandatory for all staff to attend. The overall trend in the number of patients with pressure ulcers had come down in 2014.

There were systems in place to pass on the outcome and learning from incidents to all staff. This was usually through team meetings where incidents were discussed. We saw copies of recent 'Comms Cascade' bulletins addressed to all staff at the trust. The section 'Actions you should take' included a reminder of the Trust policy and procedure on transporting of personal identifiably data as a number of recent incidents had involved the loss of data of this type whilst in transit. The bulletin also set out the procedure for reporting pressure ulcers and the rationale for learning from incidents

However, some staff said that they were not always told of the action taken and the outcome after they had reported incidents. They said that some incidents, such as reports of pressure ulcers, were dealt with thoroughly and staff were informed of the outcome. They felt that the action taken in response to some other incidents, such as reported staff shortages, was not always clear to staff.

Cleanliness, infection control and hygiene

The clinics and outpatient departments visited were clean, well ordered and uncluttered. Staff working in the clinics and in the community demonstrated appropriate practice to reduce the risk of spreading infection. This included appropriate hand washing and use of disposable gloves and aprons, and correct techniques for dressing wounds.

The Trust's target was for 100% of staff to attend infection prevention and control training every year. This target had not been met as the percentage of adult community health service staff attending this training ranged between 55% to 83% across the areas and teams.

Maintenance of environment and equipment

The premises we visited were appropriately maintained. Some clinics were in older buildings and so the layout and facilities were not as suitable as the more modern buildings. For example, at the North Cambridgeshire Hospital clinics on the first floor were accessed by stairs or a stair lift. There was no passenger lift which would make access easier for people using wheelchairs or with limited mobility.

Requires Improvement

Are Community health services for adults safe?

Staff said the equipment they used was sufficient and was appropriately maintained. Where appropriate, staff used sterilised equipment that was disposable or for single use before being re-sterilised. In a podiatry clinic, we saw that staff used sterilised equipment for each patient. Staff checked the equipment was sterile and recorded the individual number of the equipment in the patient's notes. This meant the equipment could be identified if there were any subsequent problems.

A District Nurse had found that patients' care staff were not always checking pressure relief equipment before use, such as checking the setting of pressure relief mattresses was correct for the weight of the patient. The nurse had discussed this with colleagues and they were now involved in educating patients and their care staff about ensuring the safe use of equipment.

Medicines

Medicines were safely managed. Staff administered medicines as prescribed and completed records of this. Staff knew to report medication errors and described examples where this had happened and the action taken.

Safeguarding

Staff could describe types of abuse and the procedures to follow if abuse was suspected or alleged. Safeguarding procedures and incidents were discussed at team meetings.

The Trust's target was for 95% of staff to attend training in safeguarding vulnerable adults every two years. This target had not been met in all areas. The percentage of adult community health service staff attending this training ranged from 79% to 100%.

Records

Paper records were stored securely and electronic records were protected by password access. There were systems and protocols in place for sharing information with others, such as with GPs or with medical staff from other NHS trusts. Staff could describe how people's confidentiality was protected.

Between April 2013 and March 2014 the Trust reported five incidents where confidential information was unintentionally disclosed. One of the Trust's measures to reduce the risk of this happening again was for staff to attend training in information governance. However, the staff attendance for this training was low, ranging between 19% and 65% in the various areas and teams. This meant that staff may lack awareness of how to prevent further unwanted disclosures of confidential information.

Lone and remote working

Staff were aware of the Trust's lone working policy and knew what they should do to keep themselves safe when working alone in the community. Lone working arrangements were in place in each area. One team of District Nurses and community nurses used text messaging to report their whereabouts and to confirm they had returned home safely. Staff said this worked well and they felt safe using this system. However, staff from another nursing team said they felt the lone working arrangements were not sufficient, particularly when working on dark evenings in areas where they felt vulnerable.

Staff working in the Community Assessment and Rehabilitation Team (CART), based in Luton told us there was a procedure for checking in and checking out when they had arrived at and were leaving a patient's home. They told us that risk assessments were undertaken and if a visit was assessed to be a high risk, they would go in pairs rather than go alone. High risk visits were flagged up on the computer system. However, only one of the ten staff that we spoke with told us they had attended lone worker training.

We spoke with community healthcare assistants in Peterborough. They described various methods and means that the Trust had provided to ensure their safety, although not always used by them. "The lone works device [that we carried around our necks] was clumsy and not practical but they always respond quickly. We have mobile phones and we have to call in after late calls"; "We can always call a manager if we need support or feel unsafe. Somebody always knows where you are". Community care assistants told us that they have lease cars and did not have to rely on public transport.

Adaptation of safety systems for care in different settings

We noted at Respite House, part of the drug and alcohol service in Luton that a large ground floor room had been converted to a bedroom designed for safer use by people unsteady on their feet or vulnerable to self-harm. We observed staff supporting people to safely manage their daily medication including controlled drugs. There was a

robust and safe system of checks to prevent medication administration mistakes and ensure people received their medication as prescribed by their GP. This included clear and up to date record keeping.

Assessing and responding to patient risk

People who used the service had individual risk assessments in place, such as for the risk of developing pressure ulcers or the risk of falls. Most of the risk assessments seen had been regularly reviewed and updated. Staff described examples of responding appropriately to individual risk, such as obtaining a suitable pressure relief mattress for someone at risk of developing pressure ulcers, or referring a person with significant weight loss to the dietician.

Staffing levels and caseload

At our previous inspection of the Trust in December 2013 we found inadequate arrangements to plan, monitor and evaluate staffing arrangements in the community nursing service. Minimum staffing levels set by the Trust had not always been met and staff were overstretched. The Trust's recruitment to vacant posts was not effective and some posts were vacant for more than two months. This reduced the Trust's ability to deliver the staffing resources required to meet patients' needs through the community nursing service in Cambridgeshire and Peterborough. In March 2014, the Trust sent us a report on how they intended to achieve compliance with the essential standard on staffing and stated this would not be fully achieved until March 2015

At this inspection we found that progress was being made. The Trust had identified 'hot spots' or areas where there were staff vacancies that were difficult to fill. It had invested in the district nursing service in Cambridgeshire and Peterborough and had recruited some staff in these areas. The Trust recognised the ongoing risks related to staffing levels and recruitment was continuing.

The Trust had introduced a variety of recruitment approaches, including the use of social media and recruitment days, as well as new models of mentoring and rotations in order to attract applicants. The "Releasing Time to Care" programme was working on streamlining processes and documentation and reducing administration in the district nursing service. The project initiation document dated December 2013, presented the background to the programme, interdependencies with other projects and success criteria. The Trust's clinical scrutiny committee provided a breadth of expertise to influence priorities and encourage shared learning.

Staff mostly said that staffing levels and skill mix were appropriate in their teams. A member of staff at Respite House in Luton told us that staffing levels were well managed and sufficient to meet the needs of people who used the service. At Doddington Hospital we saw from audit data displayed on the staff notice board that unplanned absences were kept under review. A member of staff told us that they had a very low staff turnover in the outpatient clinics and that staff sickness levels were not an issue. We found in the Physiotherapy department at Hinchingbrook hospital that staffing levels were good with only one locum physiotherapist who was supporting a vacancy that had been filled.

During a home visit at Luton, our contact with District Nurses did not raise any issues with staffing. Staff reported that the patch was busy but they thoroughly enjoyed district nursing. We saw they had a good rapport with patients and had been able to conduct thorough in patient assessment.

Community occupational therapists (OTs) at Huntington told us that the service was organised with different pathways for people depending on their needs with one OT who looked after urgent need referrals. A triage system screened and accessed the relevant pathway for each person and the 'duty' system ensured that the team responded to every referral.

District and community nurses from one area said that weekend cover was not sufficient. They said this meant that staff who worked weekends did not have sufficient time for each patient. Staff who worked in the musculoskeletal clinic in one community hospital said it was not always possible to find cover for staff on leave. This meant that people sometimes had longer waits for assessment or treatment.

Deprivation of liberty safeguards

We saw from care files at Respite House in Luton that people consented by signing to the care programmes that they received. People knew that they were free to leave the service if they wished.

Managing anticipated risks

Requires Improvement

Are Community health services for adults safe?

A senior staff member at Hinchingbrooke Hospital musculoskeletal physiotherapy outpatients department told us, “We are safe; we have a longer waiting list [for physiotherapy services] than we would like but we don’t keep patients needing urgent treatment waiting to be seen. The aim is to see everyone within two weeks. Fifty per cent of people assessed don’t need further input; good, quick advice is really important.”

The drug and alcohol service at Respite House in Luton had been refurbished in 2013 to provide safer accommodation for women, including a women only space at the top of the house. The service was testing out safe care with the combinations of people that it admitted for short stays; for example, only people under 25 years old at one time, only women, only men at other times. At the time of our inspection we saw that there were only people of less than 25 years old using the service.

A member of staff explained to us how links to other services in a recovery pathway were made by people while they stayed in a safe environment at Respite House. This meant that when people returned home they had already made contact with other services to support them.

Good

Are Community health services for adults effective?

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

Summary

People who used the service received care and treatment that achieved good outcomes, promoted a good quality of life, and was generally based on the best available evidence.

Staff were suitably qualified and competent to carry out their roles safely and effectively in line with best practice. Staff were encouraged and supported to access training appropriate to their roles. However, staff attendance at some training did not meet the Trust's targets, and some staff felt their opportunities to progress through training were limited.

There was effective multi-disciplinary working within the organisation and with other health and social care providers.

Detailed findings

Evidence based care and treatment

Care and treatment was planned and delivered in a personalised and holistic way. Assessments and care plans covered people's health and social care needs. People who used Respite House in Luton had comprehensive assessments on their needs and condition on their files, a plan of support and a person centred 'strengths diagram' all signed by the person. People that we spoke with referred to these plans and we saw the plans on pin boards in people's bedrooms.

Care and treatment was evidence based and was mostly in line with recognised guidance and standards. For example, people who used the service had an assessment of their risk of developing pressure ulcers using a nationally recognised tool. The assessment tool takes into account strategies to prevent pressure ulcers as identified by the National Institute for Health and Care Excellence (NICE). We saw the tool in use in the locations and community teams we visited, except for one District Nursing team where staff said it was about to be introduced.

The Physio Direct service assessed people over the telephone. The assessment followed recognised good practice and was in line with NICE guidelines for the assessment and treatment of musculoskeletal disorders. For example, people were asked a series of questions to check for potentially serious conditions, and self-management of their condition was promoted where appropriate.

Staff from a community rehabilitation team, however, told us that the team was not meeting all of the NICE guidelines for people with a stroke. The team did not employ a specialist neurologist but some staff had undertaken further training to ensure they developed their skills in supporting people with neurological conditions. The stroke rehabilitation guidelines said that patients should be seen within 72 hours of discharge from hospital. Staff said they were not always able to meet these guidelines, although they did make contact with patients by telephone within the 72 hours. This meant they could prioritise patients who needed to be seen sooner.

Staff of the sexual health clinic in Ipswich used recognised guidance to manage conditions such as syphilis in pregnancy or the pathway to manage patients through pregnancy who had HIV. There were clear protocols to manage medications. As the team had relocated to a new unit they had fully revised the medication management policy. We reviewed this documentation and saw that it had been revised to take account of the new premises, working practices, security and delivery arrangements for the location. The prescription and dispensing of medications provided by specialists was governed by clear patient group directives.

People's capacity to consent to care and treatment was assessed in line with current legislation and standards. We saw that people who used Respite House in Luton had signed to indicate consent to their care programmes. Staff told us that the service was provided only to people who had requested it and who had agreed to some restrictions on their liberty in order for their two week placement to be effective. For example, social contacts were restricted and any necessary contact was conducted through a member of staff.

Staff operating the Physio Direct service said they would not carry out an assessment by telephone where the

person needing the service was unable to give their informed consent to this. Staff said that an appointment would be made for the person to be seen in the outpatient clinic.

Pain relief

People using the service were routinely asked about their level of pain and were supported to manage this. A community nurse visiting a person at home found that the person needed stronger pain relief. The nurse was able to prescribe appropriate medication and arrange to collect this immediately so that the person had relief from their pain without delay. The Physio Direct service was for people to contact a physiotherapist by telephone to get advice for their symptoms, including pain. We observed the service and saw that a person calling the service was asked in detail about their level of pain and how it was affecting their life. The physiotherapist advised the person about exercises and positioning to help relieve the pain, and also explained how the pain relieving medication prescribed by the person's GP would work best. The telephone call was followed up with a letter to the person with a leaflet explaining the exercises, and a letter to their GP confirming the advice given. The letters were generated immediately and sent out on the same day.

Nutrition and hydration

People's nutritional needs were assessed and, where appropriate, they were referred to the dietician or speech and language therapist. We saw a person with diabetes attending for podiatry treatment. The person lived alone and was unable to get out of bed without assistance. The podiatrist checked that the person always had food and drinks to hand when in bed and advised the person and their carer of the importance of this. We saw a community nurse visiting a person at home and checking they had been contacted by the dietician. This had been requested because the person was at risk of inadequate nutrition.

Patient outcomes

The care and treatment provided achieved positive outcomes for people who used the service. The majority of people we spoke with were positive about the community health services they received. Patient complaints and patient survey results were monitored on a monthly basis through the clinical operational boards.

We saw examples of positive outcomes for people who used the service. A community nurse who visited a person at home had found on the previous visit that the person preferred to sleep in a chair rather than their bed. As they were at risk of developing pressure ulcers, the nurse had brought a pressure relieving cushion for the person's chair. This meant that their risk of developing pressure ulcers was reduced and their personal preferences were respected.

A community nurse visited a patient who had been admitted to a community hospital for a period of respite care. The nurse demonstrated the patient's wound dressing to ward staff to ensure the dressing would be carried out correctly and be more likely to achieve the desired outcome. The patient said they felt reassured and more settled by having the community nurse visit the ward.

The musculoskeletal and podiatry staff teams included 'extended scope practitioners'. These were staff who could undertake tasks that may have been previously undertaken by medical staff, such as requesting scans, x-rays or blood tests. This meant that people did not have to wait to be seen by medical staff or return to their GP if further investigations were needed. Most people we spoke with who were receiving physiotherapy as outpatients were satisfied with their treatment. One person said, "I feel my physiotherapy is helping me to stay independent."

A patient satisfaction survey was carried out in March 2013 regarding the Physio Direct service. The results of the survey showed that the majority of patients were satisfied with the service and would use it again. Patients commented, "The physio spent a long time listening and asking the appropriate questions to elicit the problem. His advice was helpful and effective. My sincere thanks." and, "I was referred to the weekly exercise class which I found to be just what I needed. Thank you for giving me the tools to manage my condition." Individual problems highlighted by patients in the survey had been addressed by increased staffing, staff training and guidance, and improvements to the telephone system.

The Acute Geriatric Intervention Service (AGIS) was a joint project with the East of England Ambulance Service. A multidisciplinary team comprising an ambulance clinician, physiotherapist, occupational therapist and consultant geriatrician, was able to deliver an immediate response following a fall. Local defined outcomes were to reduce

urgent and unplanned hospital attendance and admissions, and to improve patients' experience. For the 12 month period from April 2013, the service had exceeded its target of avoiding 264 admissions.

Performance information

Performance information about community health services was included in the Trust's quality monitoring 'dashboard' system. This included information about patient safety, incidents, infection prevention and control, and patient experience.

Staff were aware of the performance information and said this was discussed with them individually and at team meetings. Performance information was also shared through the Trust's weekly 'Comms Cascade', along with action plans to improve performance. Staff described plans to improve patient outcomes as a result of performance monitoring. An example of this was community nurses working together with GPs to improve care for people at the end of their lives.

We did not see any performance information on public display in any of the locations we visited. This meant that people who used the service did not have easy access to information about how well the service was performing, for example how long they might wait for an appointment or treatment.

Competent staff

Overall, staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. Staff at all levels that we spoke with in all the locations we visited told us they had an induction programme. Most staff we spoke with said they had completed their mandatory training up to date. However, we noted from data provided by the Trust that the target of 95% of staff completing this training annually was not met.

Staff said that their training needs were identified through supervision and appraisal and they were encouraged and supported to attend training. They were able to request training that was in addition to the mandatory training. Community nurses told us they had been supported to achieve the District Nurse qualification and also to attend mentorship training. Nurses and other healthcare professionals said they were supported to attend study days and courses related to their professional practice. Staff had regular supervision and annual appraisal from their line managers. However, a community therapist told us they were sometimes asked to work outside of their remit and provide care to patients with specialist needs for which they had not been trained. We found further evidence of this in the inpatient services where therapy input was provided by community based teams.

However, some healthcare assistants and administration staff were not always able to access training to allow their personal development. Managers at a community hospital told us there was now little opportunity for administration staff to develop as their National Vocational Qualification (NVQ) programme was removed two years previously and staff still complained about its absence. Healthcare assistants told us that the Trust used to support staff to gain nursing or therapy qualifications but this no longer happened. "There is nowhere for us to go now once we reach our band ceiling. I am really disappointed; I'm NVQ level 2 so I can't do certain procedures. If we identify certain things we want to learn like bladder wash out or insulin administration training it's possible to have it agreed but there is no programme mapped out for us. If these procedures were done by us it would save the district nurses coming out".

A member of the administration team at a community hospital told us that they were up to date with mandatory training requirements but they were, "Too busy to do any extra training."

Use of equipment and facilities

The facilities and equipment in use generally reflected good practice and had a positive impact on outcomes. Most staff said they had access to sufficient equipment to provide care and treatment. Some staff said they did not have sufficient IT equipment as this was not always repaired or replaced as required.

We saw at Doddington Hospital that there were curtains to screen off individual treatment areas in the outpatient clinic. However, the curtains did not screen sound and we could hear the dialogue between people and therapists from outside the individual treatment areas. There was one private room available if staff needed to talk with a person about more confidential or sensitive matters. People's privacy and confidentiality was not sufficiently protected when they were using the individual treatment areas.

Multi-disciplinary working and working with others

Good

Are Community health services for adults effective?

There was proactive and effective multi-disciplinary working within the organisation and with other health and social care providers. The community nurse teams told us about working closely with GPs and we saw this working effectively to ensure the right care for a patient at the end of their life. The community matrons said they worked across organisational boundaries to ensure patients had the right care. This included working with local authority social services staff and also with Age UK.

The new sexual health clinic in Ipswich was the base for all services across East Suffolk. Commissioners had developed the new model with the Trust to enable central coordination, sharing of resources and expertise across the County. The specialist staff of the sexual health team were located with the reproductive health specialist team in the new unit. The teams had developed a range of competencies for both areas of care and were developing shared duties and responsibilities. This meant that when the demand from patient attendances was for a particular type of care then all staff resources could be used effectively to provide effective assessment, care and advice. The teams met and collaborated with other services across the region including a region wide group that monitored late diagnosis of HIV, a teenage pregnancy group and domestic abuse services. The sexual health service worked in collaboration with volunteers and workers of the Terrence Higgins Trust to provide advice and testing in community bases and night clubs. Charity staff were trained in advice giving and testing instructions and dealing with samples and documentation.

The specialist diabetes service included multi-disciplinary working with podiatrists and dieticians. A diabetes specialist nurse told us that each team in their area was allocated to a GP surgery and did outreach work there. They said, “We have done a lot of training with nurses [about adjusting insulin levels] and we give a lot of support to our patients including over the ‘phone.” A diabetes consultant told us of plans to move the young adult’s diabetes clinic from the community hospital to a local health centre as there was good support there from community nurses, diabetes nurses and dieticians.

Community healthcare assistants in Peterborough told us that other workers responded quickly to requests for intervention to care for their patients, “The District Nurses are very good about palliative care patients- they respond quickly when we need them, even to change a syringe driver”. However, they said there were sometimes delays in social care packages being arranged for people ready to be discharged from hospital. They told us, “We get frustrated if we go in to [help] rehabilitation patients and there is nothing for us to do, [this means] our palliative care patients can’t come out of hospital and time isn’t on their side”.

Staff and people who used the service at Respite House in Luton told us that they had access to doctors and nurses who came to run clinics there five evenings a week. We saw that care files included a record of the multi-disciplinary professionals currently involved with the person’s care and a chronology of their interventions.

Co-ordinated integrated care pathways

The community rehabilitation teams were made up of occupational therapists, physiotherapists and support staff and were based in community hospitals and health centres. They worked closely with community nurses and social services staff. Staff from the community rehabilitation team saw patients on inpatient wards and then when they were discharged home. This meant there was a co-ordinated approach to ensuring patients had all the care and equipment they needed at home.

The community matrons acted as co-ordinators for the care of people with complex healthcare needs. They ensured that people had all the care they needed at home, including the input of GPs, community nurses, therapists and social care staff. This meant that people had their care delivered in a co-ordinated way without duplication of services.

Staff at Respite House in Luton told us that the community drug and alcohol services and shared care service referrals were part of a person’s overall care plan and the service, (at Respite House), was part of a wider system of recovery pathways. Key workers came into the home regularly to plan the aftercare with people they had referred to the service. Discharge arrangements were planned by these keyworkers before people came into the home for their 14 day stay. We spoke with a key worker to a person who was staying at Respite House at the time of our visit. They confirmed how links with other services were made while the person was in a safe environment at Respite House and how they supported the person to create pathways to recovery for after discharge.

Good

Are Community health services for adults effective?

Clinics specifically identified to meet the needs of people using the drug and alcohol services were provided at the shared care facility in Luton. The clinics included a TB clinic, smoking cessation, hepatitis and midwifery.

Good

Are Community health services for adults caring?

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

Summary

People we spoke with who used the service were positive about the way they were treated by staff. People said they were treated with compassion and respect. We saw staff ensuring that people's dignity and privacy were upheld.

People were mostly involved in making decisions about their care and treatment. We saw that people's individual preferences, culture and background were respected and taken into account when planning and delivering care. People were encouraged and supported to manage their own care where possible and to maintain their independence. People had appropriate emotional support and were helped to keep in touch with their family and friends.

Detailed findings

Compassionate care

People who used the service were treated with kindness and compassion. People were positive about the staff that provided their care and treatment. A relative of a person with dementia said staff took time with the person to ensure they and the person understood each other. We heard a nurse in an outpatient clinic explaining to a person who used the service about their prescription and where they should take it. We saw a person who arrived at the wrong clinic reception being taken by the receptionist back to the main reception desk to be booked in.

Healthcare assistants we spoke with told us, "[Caring] is something that is drummed into us from day one. We are passionate about what we do. We do a lot of end of life care and the patient and their families are our focus". People who used the drug and alcohol rehabilitation services in Luton told us that staff were very caring, "They look after you well here, all the staff are nice, they welcome you."

Reception staff at one community hospital told us that some physiotherapists telephone people when they have failed to attend an appointment and give them a certain amount of time to contact the department again before they get discharged for non-attendance. We heard a receptionist talking on the telephone in a warm and friendly manner to a person who wanted to rearrange their appointment date.

The Trust made use of some apartments in the community for people who needed further rehabilitation between hospital discharge and returning to their own homes. Three people who used this service told us although they received a number of visits daily from health and care staff they felt isolated and lonely in these apartments. We saw that the apartments did not promote people's wellbeing as they were sparsely furnished and not homely.

In the sexual health clinic, staff were caring and open in their approach to patients. We examined patient feedback written on twelve satisfaction questionnaires. One person had written, "The doctor was very friendly and approachable." All patients had written that they were confident in the staff and they had been friendly.

Dignity and respect

Staff respected people's dignity, individual preferences, culture and background. A person who used the service said, "The fact is that District Nurses live in the real world. They talk to you respectfully and respect your culture and rules. They explain things properly." We saw physiotherapists and podiatrists ensuring people's dignity was maintained during treatment in clinics, and a community nurse showing respect for the cultural needs of a person who used the service and their family.

We observed a person being treated at a diabetes clinic. The person's first language was not English and the clinic had arranged for an interpreter to be available for the consultation. We noted that the nurse treated the person and their baby with respect and put them at ease. The person was shown how to use the prescribed equipment and was given an explanation of the cause of their particular type of diabetes and its likely course in the future. The person was pleased and told the nurse that no one in their own country, from which they had recently moved, had offered an explanation of the condition before.

Two people commented to us about difficulties in finding their way around two of the community hospitals they had attended. They said, "The hospital only has written signage so it's very difficult for someone who doesn't read to find

their way round." and, "The layout and signage is confusing. Some people can't read. I've seen people trying to find their way round the place. Hospitals rely on people being able to read - why can't they use colour coding?"

The facilities of the sexual health clinic were designed with privacy and dignity in mind. Some consultation rooms had en-suite toilet facilities so that patients did not have to walk along corridors to provide samples. Curtains were in place inside doors so that even if a door was opened from outside there was still privacy if the patient was being examined. Staff were very aware of the dignity of patients. In returned satisfaction questionnaires from 2013 surveys all patients had indicated they had been treated with dignity and respect

People using Respite House in Luton told us that although meals were planned in advance, "If you don't like what's on the menu they offer you something else". We saw that planned menus included halal and vegetarian food. We spoke with a person using the service and they confirmed that staff supported them to prepare food that was in keeping with their religious beliefs.

At Respite House we heard staff speaking with people and responding to their needs with patience and warmth. We noted a portable screen in a ground floor bedroom that was near the communal rooms. Staff told us that they had asked for this to be provided to give people with complex needs who used the room some privacy from the main hallway of the house when staff entered the room to assist them with personal care.

Patient understanding and involvement

Most people who used the service were involved in making choices and informed decisions about their care and treatment. Most people said they had been given sufficient information and they understood the choices available to them. One person said, "Overall, I've found my treatment to be excellent. The staff can't do enough – they give lots of time; they ask you if you understand everything and repeat things if you're not sure. They know what my illness is and don't ask me to repeat things each time I go in. They listen to me which makes me feel very comfortable." We saw staff explaining care and treatment and checking that the person had understood before asking for their consent to continue.

We saw that information leaflets were available about a range of conditions and about the services provided. The leaflets were available in languages other than English, or in large print if required. Staff said they had access to a telephone interpretation service if needed.

Patients were fully involved in the assessment and planning of their care at the sexual health clinic in Ipswich. On arrival patients completed a self-triage questionnaire which enabled reception staff to decide which clinical staff would be most appropriate. We saw there were many patient information leaflets available and staff told us these were provided in clinic rooms at the time advice was given so that messages were clear. Patients were able to take their own clinical samples and this was supported by clear instructions where needed. The service had several consent forms that patients could sign to indicate their agreement to the different tests or procedures offered such as contraceptive injections or implants.

We saw at Respite House in Luton that people using the service had signed their support plans to indicate their involvement and agreement. People had developed 'strengths diagram plans' with support workers to manage their recovery from alcohol and substance misuse.

The three people we saw using the community rehabilitation service said they felt they were not involved in planning their care. They did not know what arrangements had been made for them to go home. They were staying in apartments used by the Trust to provide support to people who were ready for discharge from hospital but who needed more rehabilitation before going home.

Emotional support

People who used the service and their families and carers were given emotional support by staff. We saw that where people chose to be accompanied by relatives or carers, staff included them in explanations and support. The community matrons gave people a mobile telephone number on which to contact them directly. The community matrons said they often had calls from the patient's family and they were happy to provide this support, "It's about looking after the whole family, not just the patient."

Staff at Respite House in Luton told us that people who used the service agreed to a behaviour contract for their

Good

Are Community health services for adults caring?

safety and recovery that included no direct social or family contact for the 14 days that they stay at the service. They said that staff did, however, make calls on behalf of the person on request to family or specific friends if necessary.

Promotion of self-care

People were supported to manage their own health and care when they could and to maintain independence. We saw that people using the Physio Direct service were encouraged to manage their own health. They were advised by staff about managing their pain, using exercises and changes in lifestyle to make improvements in their health. Staff in the rehabilitation team took time to explain the benefits of maintaining independence to people using the service.

We went on a home visit with a community occupational therapist. The aim of this home visit and planned intervention was to promote the person's self-management and independence. We saw that the person was informed of each intended change to their home environment and the therapist sought their consent and comments. We observed a consultation with a person using a diabetes clinic. The person was asked to keep a log of daily self-test results and then send the data by text message to the specialist nurse at the end of each week.

Good

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

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

Summary

The Trust delivered appropriate services to meet the needs of different people. People were able to have their care and treatment close to home, and there were a number of teams and projects working to avoid hospital admissions.

Community nursing and rehabilitation teams were stretched due to staffing shortages. However, people usually had access to the right care at the right time, including urgent care. Some areas occasionally had long waiting lists for rehabilitation services.

People were encouraged at a local level to provide feedback or make a complaint about their care. Information about how to do this and about the action taken by the Trust in response to feedback was not always prominently displayed.

Detailed findings

Service planning and delivery to meet the needs of different people

Care was person-centred and promoted good health and independence. We saw that District Nurses and community nurses delivered care that was focussed on the needs and wishes of the person using the service, including the support required by relatives and carers. Care and treatment provided in the musculoskeletal clinics promoted people's independence and self-care.

Children aged 11 to 16 years could attend the adult musculoskeletal clinic if they chose to. Staff said they would usually see children towards the end of the day when the clinic was not so busy, or on a special Saturday morning clinic.

Provision was made for people who did not have English as their first language. Staff could access interpreter services and written information could be provided in other languages or in large print.

Access to care as close to home as possible

People were able to access care and treatment close to home in local community hospitals, clinics and treatment centres. People told us they were offered appointments in clinics or hospitals that where local to them. People who had inpatient treatment at an acute hospital in Norfolk could choose to attend their outpatient appointments at North Cambridgeshire Hospital. People we spoke with said they liked this as it was nearer to home and so saved them time and money.

The Trust had services to promote the independence of people in their own homes, avoid hospital admissions, and to ensure safe discharge home as soon as possible for hospital inpatients. This included intermediate care teams, rapid response teams, and 'step down' beds in community hospitals. Staff from one of the intermediate care teams told us about plans to facilitate early supported discharge from hospital. This would mean that people could be discharged sooner from hospital and could continue their rehabilitation in their own community. A scheme in Peterborough, called the FIRM, was re-launched in April 2014 following a successful pilot. This was led by a GP and involved close working between health and social care professionals to identify older people who are acutely unwell and at risk of hospital admission. These patients receive rapid support to enable them to remain in their own homes wherever possible, or to receive care in the local community hospital.

Access to the right care at the right time

People were referred to the District Nurse service by their GPs or on discharge from hospital. There was a single point of access (SPA) contact number and email address to streamline the referral process. There were processes in place to ensure that people with urgent needs were seen as soon as possible. Most of the District Nurse teams had an allocated nurse to carry out any unplanned care each day. This was often people at the end of their life, or people needing unexpected urgent care, such as dealing with a blocked urinary catheter. The community matrons had a triage system where patients' needs were assessed and they were seen urgently if required.

Community nursing and rehabilitation teams were stretched due to staffing shortages. We received some feedback that patients were not always seen after referral, or the service was not sufficiently flexible to meet people's needs, but others told us they were happy with their access to services and with waiting and appointment times. People who used outpatient clinics said they had not had

Good

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

to wait too long for an appointment and were not kept waiting to be seen when they arrived. Most teams were meeting the Trust's and commissioners' targets for referral to treatment, but there were some areas that occasionally had long waiting lists for rehabilitation services. Managers held daily escalation teleconferences to monitor and review the situation.

In Cambridgeshire, performance information reported to the adults and older people's clinical operational board in April 2014 showed that teams were tracking frail elderly admissions so as to ensure suitable plans of care were in place. Teams were also able to review assessments and care plans following discharge from hospital in nearly 90% of cases.

At Doddington Hospital staff told us that musculoskeletal clinic waiting times had been reduced by operating a new system whereby urgent cases were seen within a working week and routine appointments were attended to in different ways. Local GP's had been offered an education event to enable them to give appropriate advice for minor problems and reduce the progression to chronic conditions. There was a website where people could ask questions and use a screening tool to self-assess their condition as low, medium or high risk.

The Physio Direct service offered assessments over the telephone with a physiotherapist. Urgent appointments could be arranged within a week of the person contacting the service if this was felt necessary. Staff told us they would use their professional judgement regarding urgent appointments, for example, if a person's work and lifestyle was significantly affected by their injury. We heard at Doddington Hospital a physiotherapist giving a person a telephone number to use in case they had any concerns about their condition in the 3 months after treatment.

A person who attended a musculoskeletal clinic was pleased they could get an appointment to suit them and that the physiotherapist could refer them directly to other services for further investigations. The person described it as, "A very cohesive service." We saw that text messages were used to remind people of their appointments in the musculoskeletal clinics. People said they found this useful and staff said this had cut down on people not attending for their appointments.

Staff at Respite House in Luton told us that people had a standard 14 day stay admission to the service. People were admitted on a Monday or Tuesday so that they, "Have a good run" of seeing the medical staff who attended the service on weekdays.

Flexible community services

District and community nursing services were flexible around the needs of people using the service. Staff said they prioritised people according to need and there were arrangements in place to ensure urgent needs were appropriately met. The community matrons said they were able to be flexible and work across professional and organisational boundaries. One community matron said, "We're lucky in that we're not bound by defined tasks. We would never say 'it's not my job'."

We saw community rehabilitation teams working flexibly to avoid hospital admissions for people at risk in their own homes, such as people at risk of falling. This included rapid response and re-ablement services. A member of staff at a community hospital outpatients department told us that urology services were aiming to provide a 'one stop' service for people. This meant that consultants offered as much of the service as possible on that site to avoid people having to go to other hospitals in the county.

A member of staff working in the drug and alcohol services had developed links with a midwife at the local hospital who was interested in supporting the needs of pregnant women who used the service. This had resulted in a weekly midwifery clinic being provided on site. Staff had also worked with local commissioners of services to arrange for a dual diagnosis service with mental health to be provided on site twice each month. This avoided people falling between access to services for either mental health issues or for alcohol dependency.

Meeting the needs of individuals

As part of the assessment and care planning process, people had the opportunity to discuss their preferred name, religious beliefs and any specific cultural needs. The provider had arrangements in place to meet the diverse needs of people using the service. One example of this was the Coronary Heart Disease Team in Peterborough. This team offered a service to patients following a cardiac event. There were bi-lingual nurses in the team who spoke Urdu

Good

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

and Punjabi to meet the needs of the Asian population in Peterborough. People of Asian descent have a higher incidence of heart disease and many of Peterborough's Asian population do not speak English.

Moving between services

Three people who used the community rehabilitation service did not know what arrangements had been made regarding their discharge home. One of these people described the service as, "Good and bad." They said they were happy with the help to improve their mobility and ability to cope at home, but they were anxious about what plans had been made for them to get home.

Complaints handling (for this service) and learning from feedback

The provider had received 187 formal complaints between April 2013 and March 2014. The number of complaints received had reduced over this 12 month period. The musculoskeletal service had received the most complaints overall, and these were mostly related to delays in diagnosis, treatment or referral.

Information about making complaints or raising concerns was available in the community hospitals and clinics. It was not always prominently displayed to ensure that people using the service could easily find it.

We saw at four sites "You said / we did…" information on public display. These were local issues that had been raised by people who used the service and the Trust's response. For example, at Respite House in Luton: 'You said: food including lunch is disorganised. We did: We have now resolved problems with our suppliers.' The outpatient service in the Princess of Wales Hospital had received comments about the lack of a reception desk, making it difficult for people to find their way to the right clinic. We had also received a comment from a person using the service about this issue. This concern had been escalated and the Trust was looking into recruiting more volunteers to staff a reception desk.

We saw recent analysis of patient comment cards at one community hospital. Out of 57 comments for April 2014 only six were negative and four of those comments were about waiting times. However, this information was in staff areas and not on public display. Staff told us that they discussed at meetings how they could improve on the negative areas. A community occupational therapist told us that during one week each month the therapists gave feedback sheets to their patients for every intervention that week. This information was collated by the team leader and discussed at the senior therapists meeting and displayed on a board in the team room. This meant that the patient experience of the service was being evaluated in real time.

One group of staff told us that they gave people, and their relatives, good explanations about why they were carrying out interventions and this avoided grievances and complaints. The community matrons said they developed a good rapport with people using the service and their relatives so that any problems could be 'nipped in the bud'. They said this usually avoided complaints.

Good

Are Community health services for adults well-led?

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

Summary

The Trust's vision and strategy for delivering high quality care was referred to on their website and in their communications to staff. Most staff we spoke with said there was good communication from senior managers and they felt respected, valued and supported by their line managers. We did not see information about the Trust's vision, values or strategy prominently displayed in the community hospitals or clinics we visited.

There were leadership development opportunities for staff, and many staff groups had put in place new ways of working to improve their services. Staff were committed to providing good quality care and were proud of their work.

Detailed findings

Vision and strategy for this service

The Trust's vision was referred to on their website and in the weekly 'Comms Cascade' for staff. However, we did not see information about the Trust's vision, values or strategy prominently publicly displayed in the community hospitals or clinics we visited. This meant the Trust's vision and strategy for delivering high quality care may not be accessible to or understood by all staff and people who use the service. It also meant that people using the service could not always be sure who was providing the service, for example, in sites where other providers were operating or in remote locations, such as small health centres predominantly providing GP services.

Governance, risk management and quality measurement

Performance data was collected for each team and area. This included use of the NHS Safety Thermometer, a tool for measuring, monitoring and analysing patient harms and 'harm free' care. The target for harm free care was 95%. Results for the five geographical areas covered by the Trust were slightly below this.

Staff knew how to identify and report risks and said they were encouraged to make suggestions for improvement. The exception to this was staff from one team of District and community nurses who felt they had not been properly consulted about changes to the service in their area.

The Trust used an early warning trigger tool (QEWTT) to report emerging issues of concern at clinical team level each month. The tool uses an escalation matrix to highlight concerns in teams which could affect the delivery of safe patient care. The data was considered as part of the integrated governance at clinical operational boards in order to gain a comprehensive assessment of risk and to support teams to effectively implement actions to prevent adverse outcomes for patients. District and community nursing teams, were rated as high risk on the tool. These were related to staffing levels, including staff sickness rates. We saw in clinical operational board meeting minutes and quality reports to the Board that a range of strategies were in place to reduce the risks.

Leadership of this service

Most staff said there was effective communication and leadership from senior management. They said the Chief Executive and other senior staff were well known and many staff had met them. Leadership development opportunities were available to staff through in-house and external programmes. Staff told us they had been encouraged and supported to attend management and mentorship training.

Most staff said they felt respected, valued and supported by their managers. One member of staff told us their line manager had emailed them, thanking them for a job well done, which the member of staff appreciated. A manager said their team's ideas for improvements in documentation had been put in place and adopted in other areas of the Trust. The exception to this trend was District and community nurses from one team. They said that changes to their ways of working had been introduced without properly consulting them. They said, "We'd just like to be asked our opinion and we want to be listened to." and, "We're frustrated that changes are made by people who don't understand our job and what we do."

Culture within this service

Staff we spoke with were committed to providing good quality care and were proud of their work. They told us: "I

Good

Are Community health services for adults well-led?

love my job. It's such a good feeling when you can care for people properly."; "We're really encouraged to do training - it's so important so we can give good quality care."; "This is a great service! I've seen it improve over the years."

There was a culture of collective responsibility between teams and services. Staff had a cross-boundary approach to delivering care to ensure positive outcomes for people who used the service. An example of this was a forum meeting for senior staff including community matrons, District Nurses and therapists. This had been organised in response to issues raised during individual staff supervision. The forum was to discuss how best to work together to ensure people with complex needs had safe and effective care.

Managers in the drug and alcohol services in Luton told us that although operating in a different county, their service felt part of the Trust. They described systems for the exchange of ideas between services at senior manager and other meetings. They said that services within the Trust promoted their service to other service leaders. This meant staff had good information about what other appropriate services were available to people to access as part of their recovery pathway.

Most staff said they felt able to raise problems and concerns without fear of being bullied or penalised. A manager who had raised concerns about staffing said they had felt disillusioned and forgotten, but now, "Things have turned around in the last four or five months. Suddenly it's moving forward and improving. We're not constantly fighting to have our corner heard anymore."

Public and staff engagement

Staff recognised the importance of the views of people who used the service about the services provided. Staff were involved in actively seeking feedback from people. There were reminders for staff to do this in the weekly 'Comms Cascade'.

Most staff we spoke with were happy working for the Trust. One member of staff told us: "We've been through changes and there have been problems but things seem much better now. I'm optimistic about the future."

Innovation, improvement and sustainability

The Trust were involved in initiatives with other providers aimed at maintaining independence of people at home and avoiding hospital admission. This included working with a local ambulance trust and falls teams to avoid hospital admissions. We saw that the Physio Direct service had carried out a survey of their patients in 2013. They had used the results to make improvements to the service. Staff were informed of Trust wide learning events to share the lessons learned from incidents reported.