

Oxleas NHS Foundation Trust

RPG

# Community health services for adults

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RPGCJ	Bostall House	Complex Wound Care and Tissue Viability, Contenance Team, Bostall Forum	SE2 0AY
RPGXG	181 Lodge Hill, Goldie Leigh	Integrated Community Assessment Rehabilitation Team, Long terms conditions (Cardiac and diabetes teams)	SE2 0AY
RPGCJ	St Marks Medical Centre	Woolwich Forum	SE18 3EP
RPGCJ	Kidbrooke Village Health Centre	Physiotherapy	SE3 9YR
RPGZ1	The Source	Nurse Led Clinic	SE12 9DN
RPGFD	Queen Mary's Hospital	Neuro-rehabilitation Team, Integrated Musculoskeletal Services, Specialist Parkinson's Disease team	DA14 6LT
RGPX6	Eltham Community Hospital	Community Rehabilitation Team	SE9 5DQ
RPGCJ	Queen Elizabeth Hospital	Rapid Response and Care Navigation team	SE18 4QH
RPGAG	Memorial Hospital	Twilight Team	SE18 3RZ

This report describes our judgement of the quality of care provided within this core service by Oxleas Adult Community Health Services (ACHS). 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 Oxleas Adult Community Health Services (ACHS) and these are brought together to inform our overall judgement of Oxleas Adult Community Health Services (ACHS).

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

We judged that Community Adult Services were good. This was because:

- We found that there were arrangements to ensure that patients were safe, and there were systems to report, investigate and learn from safety incidents.
- We found that care and treatment was based on current guidance and best practice.
- Patients told us that they were treated with kindness and empathy and that their dignity was upheld.
- Services were arranged to respond to patients' individual needs and could be accessed when they were required.
- We found that services were well-led; with a positive learning culture which staff were engaged in and identified with.
- Governance systems were in place to monitor safety and service quality and there was an emphasis on on-going quality improvement.
- Staff felt supported by their line managers who encouraged staff to innovate and develop their practice.

# Summary of findings

## Background to the service

### Information about the service

Adult Community Health Services (ACHS) in Greenwich and Bexley are provided by Oxleas NHS Foundation Trust, a combined mental health and community trust. ACHS form one of five Service Directorates provided by the trust and incorporates district nursing services, long term conditions, pre and post hospital care and a comprehensive range of specialist community health teams in Greenwich and Bexley.

There were 15 district nursing services with a staffing component of 185 whole time equivalents. Data available one quarter (December 2015 to February 2016) showed that the district nursing teams received 4071 referrals and attended 63,376 appointments. Data for an 11 month

period to February 2016 showed that the district nursing teams had attended a total of 284,589 appointments. In the same period 29 specialist community services provided 116,817 appointments.

We visited services based at the following locations: -

- Bostall House
- Queen Mary's Hospital
- Goldie Leigh
- Eltham Community Hospital
- St Marks Medical Centre
- The Memorial Hospital
- Kidbrooke Village Health Centre
- Queen Elizabeth Hospital
- The Source

## Our inspection team

For example:

Our inspection team was led by:

**Chair:** Joe Rafferty

**Team Leader:** Pauline Carpenter, Care Quality Commission

The team included CQC inspectors and a variety of specialists including specialist nurses and an occupational therapist.

## Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme

## 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 26th, 27th and 28th of April 2016.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, allied health therapists and team leaders. We visited 12 specialist services and six district nursing teams. We talked with a range of staff who worked within the service

# Summary of findings

including the service director, clinical director, head of nursing, six managers or team leaders, and a further 38 qualified staff including agency staff as well as health care assistants.

We talked with about 20 people (including 12 telephone interviews) who use services at the clinics we visited and when we accompanied district nurses on home visits. We

observed how people were being cared for and talked with four carers and/or family members. We reviewed care or treatment records of approximately 12 people who use services.

We reviewed an extensive range of documents relevant to the running of the service including minutes of meetings, policies and performance reports.

## What people who use the provider say

Patients and carers we spoke with were very positive about the care and treatment they received from the ACHS. Those using the specialist services were particularly effusively in their praise of the expertise of staff and the effectiveness of the treatment they received. They told us about the difference these services had made to their quality of life and we saw examples of cards and letters thanking staff for their help.

ACHS received 324 compliments in 2015. Most of these were about specialist services with the diabetes team and the Bexley neuro-rehabilitation team accounting for 120. The complex wound care team, the continence service and podiatry accounted for a further 94 compliments.

## Good practice

### Outstanding Practice

The clinical expertise of many of the specialist services and the quality of care was notable.

The measures in place to learn from incidents concerning pressure ulcers involved staff from across the trust and promoted a no blame culture which supporting a learning culture.

## Areas for improvement

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

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

- Consider how a clear and comprehensive assessment of risks for lone working is carried out and recorded in patient records.
- Review arrangements for care planning to ensure that individual plans are sufficiently personalised.
- Consider how the response time for dietetic referral could be improved.

- Take action to ensure that various electronic recording systems are compatible and that staff have access to the most current information about patients.
- Consider how Mental Capacity Act Training is delivered and refreshed.
- Review arrangements the provision of printed literature to take into account the needs of people for who English is not their first language, or have a learning disability or other mental impairment.
- Work with commissioners to ensure equity of service.

Oxleas NHS Foundation Trust

# Community health services for adults

**Detailed findings from this inspection**

Good 

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We rated Adult Community Health Services (ACHS) as good for safety. This was because:

- We found that there were robust methods of reporting, investigating and learning from incidents. These were well understood by staff and were embedded in their daily work.
- There were plans to deal with a major incident or events that would disrupt the delivery of care.
- We saw that there were processes and systems that protected patients from the risk of infection and safe systems of medicines management.
- There were adequate numbers of suitably qualified, skilled and experienced staff to meet people's needs.
- Staff completed their mandatory training which was regularly updated and although there were high levels of agency staff working in some of the district nursing teams systems were place to ensure they were adequately trained and supported.
- Records were comprehensive and up to date and they supported the delivery of safe care. However not all staff had fully transferred their records to the electronic

patient recording system which meant there was the potential for care to be uncoordinated and staff who were part of integrated teams used different electronic recording systems which caused some delays in transferring patient care between services.

### Detailed findings

#### Incident reporting

- The trust had good systems in place for ensuring patient safety and for reporting of incidents. We saw that the trusts overall incident management policy was regularly reviewed by the trust's Patient Safety Group and new guidance was incorporated as this emerged. The policy set out comprehensive procedures for the reporting and managing of incidents. This included the use of an electronic reporting system, reporting time frames and the procedures for dissemination of learning from any investigations undertaken. Staff we spoke with said they were confident about the procedures required to report incidents on the electronic system.
- The NHS Safety Thermometer collects data which allows services to measure the proportion of patients



## Are services safe?

who are 'harm free' from pressure ulcers, falls and, for patients with a catheter, urine infections. The most recent data collected showed the number of patients with a catheter and acquiring a urinary tract infection had reduced over the last year and was less than the national average with only two incidents in the last 10 months. Information about pressure ulcers indicated that there was between one and three new pressure ulcers per month over the last three years which varied slightly above and below the national average although there has been a decline in the last six months. Analysis of falls showed the number of months where no falls were recorded had increased since March 2015.

- Data from the trust showed that 39 of 92 serious incidents reported across the trust from 3 December 2014 to 1 December 2015, occurred in ACHS. Charlton Forum accounted for six and Plumstead Forum accounted for eight. Serious incidents are defined as unexpected or avoidable death or severe harm of one or more patients, staff or members of the public. We looked at the analysis carried out on these incidents all of which related to the development of pressure ulcers assessed as grade three or four. We noted that that each incident had been investigated to establish the key factors causing pressure ulcers. Seven of the incidents were judged to be caused by factors that were unavoidable or had been not acquired whilst under Oxleas care.
- Staff we spoke with were aware of the duty of candour which requires staff to be open and transparent with people.

### Learning and improvement

- Mechanisms were in place to learn from incidents and audits carried out to cascade lessons and recommendations to staff. We saw that recommendations arising from audits of practice and changes to practice arising from analysis of incidents were implemented. For example we saw district nurses carrying an aide-memoir attached to their identity badges setting out key steps in pressure ulcer prevention as recommended in the audit report on this topic. Pressure ulcer champions had been created and training for staff had been made available by the complex wound team. We saw leaflets about pressure ulcer prevention which had been developed for patients.
- Following analysis of incidents relating to pressure ulcers we found action had been taken to share learning and develop practice. Methods to further reduce the incidence of pressure ulcers were vigorously pursued. A new policy had been introduced in April 2016 for the prevention, management and reporting of pressure ulcers fulfilling a recommendation from a trust wide audit of the implementation of NICE guidance "Pressure ulcers: prevention and management of pressure ulcers" (NICE CG179). Staff we spoke with were aware of the policy. We saw data which showed a reduction in grade four pressure ulcers.
- We noted that a Pressure Ulcer Panel reviewed all pressure ulcers above a level of severity described as grade two. We attended a meeting of the Pressure Ulcer Panel. Staff from across ACHS were invited and the panel was also attended by representatives from commissioning CCGs and local authority safeguarding teams. Cases were presented with a view to open and honest discussion in an atmosphere of 'no blame' in order to enable lessons to be learnt and policy and practice to be improved. We saw that open discussion was invited and collective decisions were taken about the causes of pressure ulcers. We saw that learning points were identified and recorded. We were told that these were disseminated via the minutes of the meeting, through 'practice points' being made available to staff via the intranet and cascaded to teams during staff handovers.
- We attended handovers during our visit where we saw that the learning points from the panel were passed on to the community teams. For example the panel identified the deterioration of one patient's pressure ulcer to be caused by a lack of information about the patient's pressure relieving equipment in their care plan because this information was not available for hospital staff when the patient was admitted. We saw that the need to ensure information about pressure ulcer equipment requirements was included in care plans located in patient's homes was raised in a handover.
- There was an active programme of events aimed at embedding learning arising from audits and analysis of incidents. We saw a rolling programme of events for all staff on pressure ulcer management and falls reduction as well as special one off events such as a 'Stop the

## Are services safe?

Pressure' day. Staff were aware of these and said they were encouraged to attend in work time. We noted that some events were put on at times to suit evening and night staff.

### Safeguarding

- The service had robust arrangements in place to safeguard vulnerable people. The induction policy for new staff included training on safeguarding and this was a mandatory element of the training programme. Data provided by the trust in April 2016 showed that 98% of eligible staff working in ACHS were up to date with their level one safeguarding training. We saw that 97% had completed level two and 90% had undertaken level three.
- We saw information about how to report safeguarding concerns displayed as flow charts in the offices and meeting rooms used by clinical staff throughout the trust. All the staff we spoke with, including agency staff and health care assistants, knew how to recognise signs of abuse, were confident about reporting concerns and knew who they would report any concerns to. Staff we spoke with understood the trust's whistle blowing policy and said they would report concerns externally should internal procedures not address their concerns about the safety and wellbeing of patients.
- At handover meetings we saw that potential safeguarding concerns were discussed and where appropriate safeguarding alerts were raised. For example at one handover we observed it was decided that a safeguarding alert should be reported in view of the district nurse's concern about the person's access to adequate food.

### Medicines

- We saw medicines were stored safely. Medicines were stored at temperatures that ensured their safety and efficacy. Medicines requiring storage between 2oc and 8oc were kept in a fridge. We saw that temperatures of the fridges were checked every day the clinics were open. The ambient room temperatures of rooms where other medicines were stored were also checked daily and we saw completed checklists which confirmed this. Controlled drugs were stored in line with legal requirements. We checked controlled drug registers and found that stock levels tallied.

- Medicines were prescribed by nurse practitioners who had completed a recognised course of training and were an accredited nurse-prescriber. All the clinics had access to on-line resources and current copies of the British National Formulary to ensure that prescribers could access up to date information on the safety and efficacy of the medicines they were prescribing.
- Medication safety champions had recently been appointed as part of ACHS's 'Sign up to Safety' work stream. Methods to audit the safety use of medicines were reviewed by ACHS Patient Safety Committee and the Quality Board.

### Environment and equipment

- Patients were seen in a wide variety of locations including community clinics, clinics located in Accident and Emergency hospital departments, health centres, GP clinics and in their own homes. All the locations we visited were fit for purpose. The clinics and health centres were accessible, offered privacy and were visibly clean.
- Access to equipment was positively commented on by all the staff we spoke with. Staff reported being able to order equipment easily and said that it was delivered promptly and delays were rare. We were told that when needed equipment such as pressure relieving mattresses and cushions, could be delivered within four hours.
- We saw that equipment such as oxygen and blood glucose machines were routinely checked and where equipment was seen in situ we saw testing and maintenance labels that were in date. Staff told us that equipment was properly maintained and checked including equipment requiring calibration.

### Quality of records

- We saw that Community Adult Services had recently moved to a fully electronic record system. Most staff were using the electronic system and could access information remotely. One member of staff told us how the system enabled them to check that food supplements prescribed for a person had been provided through the electronic summary care records.
- Paper records were kept at people's homes and we saw that some of the information they contained was yet to be transferred to the electronic record. Most of the staff

## Are services safe?

in the specialist services had completed the transfer to electronic recording systems. However we noted that one service were using instructions contained in correspondence rather than a specific care plan.

- Audits of care plans were undertaken to assess the usefulness of tools employed to assess care planning in ACHS. However these were yet to yield findings to inform this area of development as they were not complete.

### Cleanliness, infection control and hygiene

- We found that ACHS were compliant with the 'Code of practice on the prevention and control of infections and related guidance' issued by the Department of Health in 2015.
- We saw comprehensive range of policies covering infection control which were regularly updated. These included detailed guidance for staff such as control of MRSA and Clostridium difficile, transportation of specimens for investigation, decontamination policies, hand hygiene, general cleaning and infection control as well as reporting of notifiable diseases guidance. We saw that new guidance was disseminated promptly.
- The induction policy for new staff included training on infection control, hand hygiene and protective equipment. Training on infection control was mandatory. Data provided by the trust in April 2016 showed that 98% of eligible staff working in ACHS were up to date with their infection control training.
- Guidance on the hand hygiene policy was seen on display at locations we visited. Monthly audits were undertaken in each location of equipment and hand hygiene. Whilst scores varied across sites most were achieving 100% by the end of March 2016. The findings of these audits were reviewed by the Infection Prevention and Control Committee and the Patient Safety Group as well as the Quality Committee.
- The trust's target to maintain no incidences of Clostridium difficile or MRSA had been achieved.
- We saw that treatment rooms in the clinics were visibly clean and hygienic. Many of the facilities were shared with other providers. We saw that cleaning schedules were signed off by each professional group on completing their clinical session. Patients told us that they had no concerns regarding the cleanliness of

premises used by ACHS. Two patients we spoke with commented on the high standard of the environment in which they were treated. One said "It's attractive and cheery and absolutely spotless."

- We saw infection prevention and control audits for each location had been undertaken during the previous year. There was an overall "green rating" for most locations and we saw that the findings were reviewed by the Quality Committee.
- We saw that clinic environments had supplies of personal protective equipment (PPE). There were adequate hand washing facilities and supplies of hand sanitizer for staff and the public to use. Staff visiting people in their own homes all reported that they had adequate supplies of PPE equipment. Staff we observed providing care and treatment used PPE equipment appropriately.
- "Sharps" waste bins were provided where required and were properly labelled. This ensured that needles used for patient injections were disposed of safely.

### Mandatory training

- The trust had a robust electronic system for monitoring compliance with mandatory training requirements which showed that patients were treated by probably trained staff. We saw that team leaders were able to track the training undertaken by members of their teams. Staff told us that they received automatic email reminders about their personal training requirements, were able to access their individual training records and book on to appropriate courses with ease. They told us that they were able to complete their training within work time.
- The mandatory training courses included conflict resolution, equality and diversity, fire safety, health and safety, infection control, information governance and safeguarding. The training consisted of a range of e learning modules and face to face training.
- Managers and team leaders received reports from the system about compliance with mandatory training and the staff told us their team leaders reviewed their training records with them. We saw data which showed that 97% of ACHS staff were up to date with their mandatory training.

### Lone working

## Are services safe?

- We saw the trust wide policy for the protection of lone workers was last reviewed in June 2013. The policy provided guidance for staff delivering services on a one to one basis in community clinics as well as the provision of care within people's own homes.
- We noted that this policy required line managers to ensure "staff have received training provided for personal safety and working alone, including conflict resolution training, Breakaway training or PMVA as appropriate." We noted that mandatory training for adult community health service staff only included training on conflict resolution. Records showed that 96% of staff were up to date with this training.
- Staff we spoke to were aware of the lone working policy. District nurses regularly phoned in to the office during the day; at weekends the location of district nurses was monitored centrally by a rotating designated team leader. We heard staff discussing risks concerned with lone working at their handover meetings. Staff told us that any risks were recorded on the trust computerised system' including the need for two staff to attend patients where they were risked assessed as potentially aggressive. However, not all the patient records we looked at showed a clear and comprehensive assessment of risks for lone working as specified in the policy which meant staff may not be fully aware of the risks they may encounter, nor how to manage these.
- We looked at a sample of electronic care records. We saw that staff had access to a library of model care plans for specific conditions which included prompts to aid staff to identify risks concerned with specific conditions such as Chronic Obstructive Pulmonary Disease and Diabetes. We saw that these templates were being used to inform care plans.
- Nurse specialists we spoke with were very proficient in their areas of expertise and understood risks concerned with the provision of treatment and the particular needs of individual patients. We saw treatment and care provided took account of identified risks and staff told us of arrangements made to access other support. For example social and mental health support had been arranged where a patient's risk of depression had been identified.

### Staffing levels and caseload

### Assessing and responding to patient risk

- The teams we visited were fully staffed although there was a high dependence on agency staff in the district nursing teams. The number of shifts covered by bank or agency is the second highest in the trust. Adult community services had a nurse vacancy rate of 16% and nursing assistant vacancy rate of 21%.
- This was partly a result of varying commissioning priorities. However the trust was located next to inner London boroughs which entitled staff to higher London weighting allowances, making employment in Oxleas less attractive in respect of remuneration. We saw that the trust had proactive recruitment initiatives in place to increase the proportion of permanent staff. This included encouragement of agency and bank staff to seek permanent positions and holding wider recruitment campaigns in the community including recruitment drives at weekends.
- Staff in teams with a high reliance on agency staff told us they were able to manage their caseloads safely because the majority of the agency staff were long term regular staff and there was good leadership from their team leaders. We saw that caseloads were allocated according to the experience and skills of team members. We saw that agency staff were provided with induction training and were competency tested before working with patients with complex needs. We spoke to agency staff who said they were treated in the same way as permanent staff and felt treated as equal members of the team. They told us they had access to the same
- We looked at care records in patient's homes on our visits with the district nurses. Records included risk assessments for falls, the development of pressure sores and poor nutrition. We saw that staff used standardised accredited systems for assessing risk including the Waterlow assessment tool which identifies risks of pressure sores, the Malnutrition Universal Screening Tool (MUST) which helps identify people at risk of malnutrition and the Falls Risk Assessment Template (FRAT) as part of the patient's initial assessment. Where a risk was identified we saw that this was regularly monitored and action taken. For example during a handover we saw that a person's increasing risk of malnutrition was discussed and a referral was made to the dietician. In another example we saw that district nurses could seek advice and arrange joint visits with specialist staff including staff from the diabetes team or the complex wounds team when specific risks were identified.

## Are services safe?

training as permanent staff and were provided with supervision and support. They chose to remain non-permanent due to their personal preference for more flexible working arrangements. This demonstrated that staff were able to provide safe care because risks and issues concerned with a high level of temporary staff were well managed.

- We noted that district nursing was delivering at 23% above the commissioned number of appointments which might suggest that staff were over stretched. However district nursing teams told us they felt that whilst the case load was high they were able to deliver a safe and effective service.

- Specialist staff were able to manage their own caseloads and did not report issues concerned with staffing shortages. This meant that within the terms of the commissioning arrangements for services patients were safe because staffing levels were adequate.

### **Managing anticipated risks**

- We saw that exercises carried out across the trust to stimulate potential emergency situations included staff and managers of ACHS. In the last two years exercises carried out included an examination of multi-agency response to major incidents at one of the hospitals, and testing of the trust's plan for dealing with Flu outbreaks as well as the general business continuity plans. These meant patients were safe because plans made to deal with foreseeable emergencies were in place and had been tested.

## Are services effective?

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

### Summary

We rated Community Adult Services good for effectiveness. This was because:

- Overall, we saw that national guidance from government, the National Institute of Health and Care Excellence and professional bodies was complied with and that staff showed awareness of relevant guidance in their work.
- Staff were supported through face-to-face meetings with their manager and through an annual appraisal which generated a personal development plan for each individual.
- Staff were encouraged and supported by the organisation to gain additional qualifications relevant to their role, and staff in senior positions held appropriate qualifications.
- The trust employed a member of staff to support professional staff to remain registered with the relevant professional body.
- There were systems to gain people's consent prior to care and treatment. Where patients lacked the capacity to give consent, there were arrangements in place to ensure that staff acted in accordance with their legal obligations.

### Detailed findings

#### Evidenced based treatment and care

- Senior managers told us that the Clinical Effectiveness Group (CEG) was one of three streams of activity overseen by the Trust's Quality Committee. The CEG ensured that new guidance from the National Institute for Clinical Effectiveness (NICE), The Department of Health, or from other sources such as the Royal Colleges was reviewed by appropriate clinical directors and cascaded through to relevant teams for consideration. Practice staff we spoke with confirmed that teams were asked to identify a member of staff to assess new guidance undertaking a gap analysis and recommending changes to practice as required.
- The specialist services provided by the trust were proactive in supporting the implementation of best

practice through the provision of training which was open to all staff as well as health and social care partners. For example we saw a programme of training provided by the Tissue Viability Team on various aspects of pressure ulcer prevention and management.

- Throughout our visits to the specialist services we observed staff working to specific national guidance governing their speciality. For example we saw policies based on NICE guidelines for pain management, diabetic foot care, continence care and for cardiac care.
- We saw that care planning templates had been developed based on national guidelines and best practice to support district nurses. These were available on the trust's electronic records database and we saw that they were actively used. For example we saw a care plan where staff had drawn on guidance on best practice for caring for patients with COPD when developing patients care plan.
- As part of its quality assurance programme ACHS participated in national clinical audit programmes and confidential enquires. These helped quality assurance by providing a method of benchmarking performance against that of other providers of specialist services. Over the last year ACHS had participated in six national audits including a national audit of diabetes foot care, Parkinson's, COPD and a pulmonary rehabilitation audit.
- The current internal audit programme included an audit of dietetic progress notes, an audit of the implementing ESCAPE (knee pain classes), diabetes foot assessment audits, end of life care and the management of incontinence in women. This demonstrated that ACHS were proactive in ensuring standards of treatment and care were maintained.
- We saw that the trust carried out an annual audit of falls to assess compliance with its own policy, best practice and NICE guidance (NICE CG161). Key findings related to falls risk assessment and management. The documentation of risk was identified as a factor leading to a lack of "sufficient care planning and therefore preventative work." We saw action plans with completion dates had been drawn up to implement

## Are services effective?

recommendations to address this concern. Training events aimed at embedding learning arising from incident investigations had been held across the trust and falls champions had been appointed.

### Pain assessment

- We saw pain assessment protocols and noted that people's treatment goals included pain management. We observed that staff were aware of patients' needs in relation to adequate pain control and took care to administer pain control ahead of dressing changes which increased the person's pain. We reviewed the records of two patients with long standing Multiple Sclerosis which showed that patient's pain assessment and management plans were regularly reviewed.

### Nutrition and Hydration

- We saw that patients were assessed for risk of malnutrition using the Malnutrition Universal Screening Tool (MUST) as part of the initial assessment carried out by district nurses. Patients whose scores indicated a concern were referred to a dietician.
- However district nurses told us that accessing dietetic services in a timely way in some areas was difficult due to varying commissioning arrangement. This meant that some patients had to wait considerably longer to see a dietitian than others depending on which borough they lived in. To avoid risks to patients referred we heard that staff would, if necessary, immediately alert other professionals to address identified risks for example speaking directly to the dieticians or contacting the patient's GP. In one instance we saw that a safeguarding alert was raised due to immediate risks due to lack of access to food.
- In the specialist nursing services we saw that people were asked about their diet and advice was offered as appropriate.

### Telemedicine/IT

- We saw that staff were using hand held computers which enabled them to access the trust's computer system when working remotely. This meant they were able to access the up to date patient's records and current guidance on specific conditions. Some staff told us that they were also able to update care records remotely but others said that the systems were not able at present to update records in this way. Agency nursing staff were not issued with hand held computers

although we were told this was under consideration within the trust. This meant that staff might visit a person at home without having prior knowledge of their care plan and specific risks.

- We saw that nurses using hand held computers were able, with consent, to photograph wounds which assisted the monitoring of care and enabled specialist advice to be quickly obtained. Photographs were also used to update other health professionals such as GPs and aid prompt diagnosis. We saw staff using photographs as a motivational tool demonstrating to patient's progress in the healing of complex wounds.
- Staff used the trust's electronic records systems for storing patient records. This enabled all staff in the trust and other health professionals using the same system to share information and monitor patient's health. However staff working in integrated teams told us various electronic systems were being used by different professionals who were part of the teams. This meant they were not able to share notes which sometimes resulted in avoidable delays to referrals and patients becoming confused and frustrated by being asked the same questions repeatedly by staff responsible for different aspects of their care. Staff reported that up to four different electronic systems could be in use and we observed the use of multiple systems.

### Patient Outcomes

- We reviewed the Sentinel Stroke National Audit Programme (SSNAP) audit results for July - September 2015 supplied by the trust. These were primarily for Early Supported Discharge (ESD) teams and Community Rehab Teams (CRT). We noted that the trust performed in line with national averages for the majority of indicators. In the case of the modified Rankin Scale (mRS) scores on discharge the trust performed better than the national average meaning patients were regaining their function as a result of intervention. The mRS is a scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke.
- Individual patient outcomes were used as a bench mark to assess the effectiveness of treatment and care on a case by case basis. The trust had a target of 80% for patients to have a goal based treatment plan. All the care records we looked at contained goal based

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treatment and care outcomes tailored to the needs and wants of people using the service. For example we observed the care of one person whose goals were to achieve sufficient progress with their condition in order to go abroad on holiday.

- The patients we spoke with praised the effectiveness of the treatment received. One patient told us how the care and attention received had significantly extended the dexterity and strength of their dominant hand, compromised due to their condition. They said “most people don’t think it important but what (the Occupational Therapist) has done has changed my life.” Another person endorsed the benefits of specialist long term conditions services saying “in the short time I have been coming here there has been more improvement than the two years at the (GP) practice.”
- We saw that progress and outcomes were assessed at clinical meetings, through team meetings and multi-disciplinary care reviews. Patients responding to feedback surveys felt their treatment and care made a positive difference to their health and wellbeing.
- The trust’s board set priorities for clinical effectiveness. The Quality Report for the year 2014/15 was not clear about the achievement of the goals for that year because the data contained in the report referenced previous year’s targets.
- Two quality improvement goals were set for 2015/16 for ACHS. A target of 95% of ‘community patients’ with a recorded care plan was achieved. A target of 90% of district nurse’s patients to have a recorded care plan was not met although good progress was being made with 87% being reached by the end of the year.
- ACHS worked within key performance indicators (KPIs) required by the commissioners of their service. We reviewed data against the set KPIs for the year ending in March 2016 for one area Bexley. Of the 27 KPI’s, 23 had been completely met with a further three mostly met and one missed target was being discussed with commissioners as the service was in fact over performing in respect of levels of activity which impacted on service quality outcome measure.
- We saw that management monitored a comprehensive range of performance and quality indicators for all

services across the boroughs served. The data was reviewed at the Quality monthly meetings. The consistent concerns raised included the use of temporary staff and staff supervision.

### Competent staff

- We saw a comprehensive induction programme for new staff and saw that components of this were signed off when completed. The induction and mandatory training programme ensured all staff worked to a common baseline standard.
- Competency standards were set for the provision of complex care within the district nursing teams. The high level of knowledge and expertise of specialist nurses was very apparent. We noted that some of the specialist nurses were trained to master’s level in their speciality which meant people with specific conditions had access to treatment by staff with a high level of expertise in their field.
- In addition to the events to embed learning from incidents and audits we saw that specialist staff ran a variety of learning events which all staff were encouraged to attend. Topics included falls, pressure ulcers and wound care. Allied health professions and specialist nurses told us that they were able to attend regional and national symposiums as a means of learning and improving practice.
- We saw data from the trust’s learning and development It system which showed that staff in the teams we visited were up to date with their six-weekly supervision sessions in line with the trust’s policy. Staff consistently reported that supervision sessions provided useful opportunities to reflect on their work. One staff member said “Supervision keeps us up to date with policies. Managers give ideas and suggestions about how we can work more effectively.” We noted data which showed staff supervision continued to be a challenge although by February 2016 supervision rates had improved reaching 100%.
- Staff reported that annual reviews of their performance took place in the form of a Personal Development Review (PDR). Staff told us these were useful as goals and targets for their personal development were set. Actions were set for managers for supporting staff with their goals and staff reported that these actions were completed. For example one staff member told us “one of my goals was to go and see how things happened in



## Are services effective?

other boroughs so I could compare how care was delivered. My manager facilitated this.” Another said “It’s a very useful process. If there is training you want and it’s suitable for you and fits with your PDR - they (managers) will allow you time, and sometimes funding, to do the training.” One staff member described a course which had been identified at their PDR that had helped them deal with difficult conversations. Others mentioned courses of interest and said that team leaders were open to suggestions made in line with a person’s development needs or as a means of improving practice overall.

- We noted that the trust had employed a revalidation support officer to assist nurses in maintaining their professional accreditation.

### **Multi-disciplinary working and coordinated pathways of care**

- Patients received safe and coordinated care, treatment and support because staff cooperated and shared information with other services and agencies.
- We saw examples of multi-disciplinary working and coordinated pathways of care. For example we saw evidence in patient’s notes of joint visits. Staff described one such visit where the community rehabilitation team had concerns about a patient’s welfare and arranged for social services to accompany them on a visit to assess the situation. We heard of other examples such as joint meetings between specialist diabetes staff and the dieticians to discuss the diet of a patient diagnosed with diabetes as well as meetings between the acute service staff and the diabetes teams, and joint working between district nursing teams with the mental health teams and the acute sector to ensure coordinated care pathways.
- We visited the twilight service which provided home nursing care up to 11 pm and noted the joint working between this service and the daytime district nursing teams. Partnerships were evident with end of life specialists in order to provide overnight support to both patients and their carers.
- Community teams had close working relationships with social workers and GPs. At handover meetings we saw staff communicated with these groups either to discuss aspects of care, make emergency referrals or to seek advice.

### **Referral, transfer, discharge and transition**

- With few exceptions referrals to ACHS were dealt with within the targets set by the trust and commissioners. Where waiting times exceeded targets good arrangements were in place to triage patients effectively. Staff told us all patients were contacted within 24 hours to assure patients that referrals had been received, to assist triage, keep patients informed of the progress of their referral and to ensure expectations were understood. Staff told us that these calls frequently resulted in some needs being identified that could quickly and easily be addressed. For example, the delivery of a walking aid for a patient assessed as having reduced mobility.
- ACHS operated a number of dedicated integrated care teams aiming to support people in their own homes by working with patient’s pre and post hospital admission. Staff we spoke with had a good understanding of integrated care, understanding each other’s roles within their team and across teams and with other health and social care professionals.
- There was a hospital ‘in reach team’ which enabled community nurses to assess patients whilst in hospital to prepare for discharge. This was followed with a home visit to ensure seamless continuity of care.
- The rapid assessment team worked to prevent hospital admissions by responding to district nurses and specialist service referrals providing additional packages of which could, if necessary, be put in place within two hours.
- Staff told us that speed and efficiency were sometimes compromised by incompatibility of computer systems across different groups of professionals. In one instance a referral was received from an acute ward without sufficient information about the person’s weight bearing status. This delayed further assessment and the development of a suitable package of care as they did not have access to the patients complete set of notes.

### **Mental Health Capacity Act and consent**

- Training on the requirements of the Mental Health Capacity Act was not part of the mandatory training programme for ACHS staff, however it was a requirement that all clinical staff complete it and 95% had done so.

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- However staff we spoke with were able to describe their responsibilities in relation to the Mental Capacity Act and could describe how it was applied in their daily work. Staff told us if they had concerns that a patient lacked capacity and were unable to contribute to decisions about their care, a best interests meeting would be held with relatives and the GP.
- In all the care plans we looked at consent to the care proposed was recorded. We also saw records in treatment notes that demonstrated that verbal consent was obtained where care was provided.

## Are services caring?

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

### Summary

We rated ACHS as good in relation to caring. This was because:

- Patients and carers we spoke with consistently praised the way they had been treated by staff.
- Feedback gathered by the organisation and national data collection systems about patients experience showed good levels of satisfaction with this aspect of patient care.
- Patients told us that staff were kind and thoughtful and often provided more than patients expected in supporting them.
- Patients said they felt treated with dignity and felt involved with decisions about their care and treatment. The care we observed demonstrated that people's privacy was respected.

### Detailed findings

- We spoke with approximately 20 patients and their carers who used ACHS. We did this during visits to patients nursed in their home and contacted patients by telephone. We looked at patient feedback and the complaints the trust had received and observed three staff handovers. The information provided indicated that staff in the trust treated patients with care and compassion.
- Patients told us that the district nursing service was good. One patient said, "The staff that come to me are angels." Another said "They are kind and very caring". Patients we spoke who used the specialist clinics were very positive about manner and approach staff took in providing care and treatment. One patient told us "If it weren't for (member of staff) I wouldn't come. I know I should give up smoking but (member of staff) understands there is just so much I can deal with and I am doing my best." Another said, "They are so kind and helpful and always make sure you have a person to contact at all times".
- During a handover we saw that staff respected the different ways people dealt with their conditions. We saw they respected patient's wishes. For example one nurse treating a person with cancer recognised the patient's reluctance to discuss aspects of their end of

life. They ensured the person had information to look at when they felt ready including the nurse's telephone number as well as contact details of specialist services should they feel they wanted to talk things through at another time.

- Staff told us that each team received monthly reports of Patient Experience Feedback collected by the trust. We looked at the reports for March 2016. The number of respondents representing each service was small. However all respondents said that staff were caring and supportive. Individual comments were recorded. One person had said, "The staff have provided tender care over a long period and given me a lot of encouragement and support."
- The NHS Friends and Family test is a national survey inviting people to comment on the services they received. Data from August 2015 to January 2016 shows that 96% of patients would recommend ACHS as a place to receive treatment which is above the England average. The number of patients who would not recommend the trust was low and similar to the England average. All the staff we spoke to said they would be happy to be treated by Oxleas ACHC and would recommend the services to family members and friends.

### Dignity and respect

- The Patient Experience Feedback collected by the trust showed that 100% of patients who responded felt they were treated with dignity and respect during their appointments. The numbers of respondents was not available on the returns given to the different teams so it was not possible to be certain about the sample size and therefore the significance of the data.
- At the clinics we visited we observed that privacy and dignity were well managed with treatment delivered in private treatment rooms. During our visits accompanying district nursing staff in patient's homes we saw staff were respectful of patients' homes and matters of dignity were given due consideration.
- We saw information about PLACE assessments. These are self-assessments undertaken by teams of NHS and

## Are services caring?

private/independent health care providers, and include at least 50% of the public. In relation to privacy, dignity and wellbeing, the 2015 PLACE score for Oxleas was 92%. This was better than the national average of 86%.

### Patient understanding and involvement

- The data from feedback questionnaires indicated that most patients responding felt they had enough information about their condition and felt involved in decisions about their care although a significant number were less sure answering “to some extent”.
- Our observations of care demonstrated that staff ensured people understood their treatment and care and were involved in decisions about it. We heard staff explaining the treatment given, responding to people’s questions and asking them about their options and choices concerning treatment.

### Promotion of self-care

- Our discussions with staff and patients and observations of care showed individual patient goals were established jointly with patients which encouraged their active participants in their care. Information was provided to support effective care such as weight loss, smoking cessation and individualised exercise plans.
- We saw that patients were taught how to self-manage aspects of their care where possible. For example we saw a diet programme developed for one person with a learning difficulty. Photographs had been used to demonstrate the meals recommended enabling them to manage their diet by preparing balanced and nutritious meals.

# 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 ACHS as good in relation to responsiveness. This was because:

- We found there was a focus of providing services close to where people lived and at times that were convenient to them.
- There was provision to ensure that essential services were available out-of-hours.
- Targets for response times were met although we found that waiting times varied between Greenwich and Bexley for some services due to different service commissioning arrangements.
- We found that provision for consideration was given to patients for whom English was not their first language and people with complex needs.
- Complaints were investigated and responded to; staff were made aware of the issues raised by complaints and where appropriate changes made as a result.
- However there was little specific provision made for people with mental impairments or learning disabilities other than in the specialist services working specifically with people with a mental impairment.
- education and advice delivered as well as providing an incentive for those who were mobile, but perhaps isolated, to get out and about. This had the added benefit of creating additional capacity for home visits for those who were house bound.
- ACHS's had a role in responding to increases in health and social care demand through its Community Assessment and Rehabilitation Teams (CART) with the aim of avoiding admissions, supporting discharges and promoting community resilience at times of increased demand. A number of additional projects were undertaken to ensure the services were in a position to respond to winter pressures in 2015/16. These included additional resourcing of physiotherapists and occupational therapists to enable more patients to stay at their normal place of residence whilst receiving support. We saw that resources had been made available to help district nurses review specific aspects of care. For example a review had been undertaken of patients using catheters removing those not required which helped reduced the risk of infections and reliance on district nursing visits.

## Detailed findings

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

- People with specific conditions received expert treatment and care at a convenient location and at times of their choosing. We saw that Oxleas' ACHS operated a comprehensive range of specialist services. These included COPD services, diabetes, cardiac rehabilitation, neurological, long term conditions, complex wound care, an HIV specialist nurse, clinics for people with Parkinson's, continence service, and podiatry. The specialist services held clinics in a variety of community locations throughout the week and appointment times had been extended to provide appointments outside normal office hours.
- People were offered a choice of appointment times and at locations which best suited them as far as it was possible to do so. Some of the specialist nurses had set up group sessions for patients where information about their conditions could be shared and health promotion
- District nurses were organised into teams providing a range of nursing services across the boroughs served by the trust Monday to Friday. District nursing cover was provided at weekends with the coordination of weekend cover being arranged as a centralised team. A twilight service operated 5pm to 11pm seven days a week. District nurses worked jointly with the hospice palliative care service if support and care was required overnight. These arrangements enabled a wide variety of care packages to be provided including those which enabled people to avoid unnecessary hospital admission.
- Patients seen at some locations commented on the surroundings. For example one person said "the clinic is well placed. I can get here easily and there is disabled parking. It's near the shops so I can combine my appointment with my shopping and it's good to get out". Another commented on the décor saying "it's clean and bright. I love the deep colours – they really cheer you up."
- However, we found that access to some specialist services was affected by differing priorities and arrangements of the various Clinical Commissioning

## Are services responsive to people's needs?

Groups. This resulted in access to some services was dependant on where people lived. For example, people with diabetes living in Bexley did not receive the same the level of access to dietetics as patients living in Greenwich due to the different arrangements. We spoke to dietitians and whilst efforts were made to provide support across the whole area through promoting best practice amongst district nursing teams, it was evident that referral to treatment times varied across the as a result of commissioning arrangements.

### Equality and diversity

- We noted that there was limited information for people who English was not their first language. Staff were aware of the availability of a translation service for the trust and could describe the process for accessing this when necessary. Staff were able to give examples of when the translating service had been used and we saw data showing service uptake for the trust as a whole. This confirmed that the trust catered for non-English speakers if required.
- We asked staff about the availability of information for people living with a learning disability or other cogitative impairments. We noted that general health promotional material was available on the Oxleas' website along with other information for patients in easy read versions. However no specific information concerned with the provision of adult community health services, district nursing or about the specialist conditions catered for was available for people in easy read versions or in other languages.
- Mandatory training for all staff included training on equality and diversity and we saw that 96% of staff were up to date with this training.
- All of the services we visited were accessible to people using mobility aids by use of ramps and /or lifts. Disabled parking was available at the hospital and community locations we visited.

### Meeting the needs of people in vulnerable circumstances

- A paper copy of the patient's care plan and records about their care were kept at the person's home. We saw that these care plans were individual to each patient and provided the information to allow staff unfamiliar with the person's needs to provide

appropriate care and attention. However we noted that care plans held on the electronic records system were not always sufficiently personalised. For example five electronic care plan records we looked at contained little other than the template care plans drawn from the electronic library available to support the development of care plans for specific conditions. This meant that the electronic records might not always accurately set out care and treatment requirements specific to the patient's needs.

- We observed treatment provided to people at the clinics we visited. We found that care and treatment provided by the specialist service was planned and delivered to meet the individual needs of patients. Patients described the individual goals set for their treatment and care and we heard staff offering choices about treatment options and discussing the relative merits of different approaches with patients.
- People who may find it difficult to make appointments for health care from the Greenwich area were able to access a confidential drop-in, nurse-led service called 'The Source' for advice about healthy living, contraception and sexual health, minor illness, wound care and childhood and influenza vaccinations. This enabled people who were less able to plan appointments to access services.
- The electronic care plans we looked did not flag up any communication needs that patients might have. We saw that communication issues were highlighted and discussed at handovers and team meetings and district nurses were able to describe how they might approach, communicate and manage the care of people living with dementia or a learning disability. This lack of recording could mean that staff might arrive to care for someone without knowing how a patient with a special need may needed to be supported to communicate.
- Staff we spoke with about how specific cultural needs of patients might be catered for were unable to provide concrete examples about how such needs were met.

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

- In the last year for which full data was available the trust had exceeded its own referral to treatment time targets for 95% of non-admitted patients. Staff were able to describe how referrals were triaged and prioritised which meant that people needing to be treated promptly were prioritised.

## Are services responsive to people's needs?

- We spoke with staff from the rapid response team who explained they offered a seven day a week service 8am to 8pm to provide urgent assistance to avoid hospital admissions. Staff told us that the team were able, within 24 hours if required, to provide intensive support for up to three days to support a patient's discharge.
- The district nursing teams triaged new referrals. Where needed, staff could see people within four hours of a referral being made. We saw that a full assessment was carried out within 72 hours. The twilight and night service enabled people to receive timely care.
- Our observations of district nurses teams showed that nurses built up good relationships with other primary care providers and allied health professions and could quickly and easily access care for people if their needs changed.
- We saw that some commissioning requirements resulted in separate services for people in different locations for the same speciality although they were located on the same site. During our visit we noted patients for one service waiting for appointments at a time when the other service was not busy.
- Patients told us they had been given a form to record their feedback about their experience of treatment and care. Staff showed us the results of these which were feedback to each team monthly. We saw that important questions were asked concerning patient's experience, their view of the outcome of their treatment and whether they would recommend the service to others. Most of the feedback we reviewed from these reports was positive. However, we saw the number of respondents was not given on the monthly reports or the percentage of all patients using the service which could make it more difficult for teams to be assured of their performance from the information available.
- We asked teams how they dealt with individual formal complaints they received. Staff told us that these were reviewed by the manager and discussed with the team.
- The formal complaints we reviewed in individual services showed that staff followed the required procedure responding to the complainant in a timely fashion and apologised where appropriate for any distress caused. We saw that staff were open and willing to learn from complaints about their service. For example in one case staff had revised their protocols for dealing with GPs requests to ensure expectations were mutually understood. In another example nurses had reordered dressings to better suit a patient's needs.

### Complaints handling and learning from feedback

- The trust had policies and procedures available to support staff who wished to complain. The information given about complaints was set out in leaflets about individual specialist services and directed patients to Patient Advice Liaison Service (PALS).
- Written information about the district nursing service given to patients in their own homes also directed patients to PALS should they wish to make a complaint. Staff we spoke with confirmed that this was the usual advice given. Only a few of the patients we spoke with said they knew how to make a complaint. Those who did, mentioned PALS as the means of doing so.
- A more comprehensive process for making a complaint directly to the trust in the first instance was available on the trust's website and we saw leaflets at one location setting out the procedure stating what complainants could expect in terms of how their complaint would be dealt with and the timescales involved.
- We looked at an analysis of complaints received up to January 2016. Thirty nine formal complaints were made about ACHS. The report we looked at provided information about the nature of complaints made in the period October 2015 to end of December 2016 were eight complaints raised 31 separate issues. We saw that each issue had been investigated. Of the 15 complaints upheld the only common issue concerned inaccurate records.
- PALS had received a further 73 contacts raising 81 issues in the same period. It was not clear how these contacts had been investigated but the predominant contacts concerned clinical care and information. There were no clear records of how these issues had been resolved.

## 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

Overall, we rated Community Adult Services as good for well-led. This was because:

- There were systems to ensure good governance and monitoring of standards and performance.
- We found that there was a positive culture, with staff and managers feeling proud of their work and achievements and speaking well of their colleagues and the organisation.
- Front-line staff felt supported by their managers to deliver high quality care, and empowered to implement and participate in quality improvement projects.
- Managers were described as being visible, open and approachable.

### Detailed findings

#### Service vision and strategy

- The service directors told us that improving lives was the ‘golden thread’ linking all the services with the emphasis being on integrating physical and mental health across the geographic areas served by the trust. Staff we spoke with were most concerned their particular services and less aware of the overall plans and strategies in place for the trust as a whole. However the overall vision could be seen to trickle down because providing joined up services across community and mental health directorates was reflected in the working practices and values staff described. We saw examples of work which demonstrated this such as the provision of tissue viability specialists providing advice to mental health services and the psychological input provided within musculoskeletal and diabetes services.

#### Governance, risk management and quality measurement

- We found there was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management

team to managers of individual teams and specialist services. We spoke with team leaders who were familiar with the service’s governance structures and felt confident regarding its effectiveness.

- We reviewed the minutes of various governance meetings and found they contained information on incidents, complaints and other critical incidents, the outcome of audit activity and progress against action plans and the review of risk registers.
- We noted that there were systems for formally signing off action plans or removing risks from the register which ensured that matters were managed appropriately to their conclusion although we noted that some audit report findings were consistently deferred to subsequent meetings in recent months.

#### Leadership of this service

- All staff we spoke with told us they felt well supported by team leaders and local managers. Staff consistently told us they felt their manager was approachable and that ‘the door was always open.’ Staff in one district nursing team described their manager as ‘totally on it. She leads from the front and has high standards but she is very supportive as well’.
- Staff told us they felt their professional expertise was respected and they received positive feedback about their work from their managers.
- We saw a programme of visits board members made to different services provided within the ACHS although none of the staff we spoke had been present when visits had taken place to their team. Staff felt that directors were somewhat distant but also recognised the demands of the size of operation and did not expect significant contact.

#### Culture within this service

- Overall staff we spoke with had a ‘can do’ attitude and demonstrated a high level of commitment and energy about the provision of high quality care. Staff liked working at Oxleas and said they would recommend the



## Are services well-led?

organisation as a good place to work. One staff member said, “People work together to provide a good service and keep waiting lists down; we support each other and help improve the service.”

- Staff described the culture and open and transparent with an emphasis on learning and improvement. Staff said that there was a commitment to joint working across the different specialisms with community health services, within the wider trust and with other partners in health and social care.

### Staff engagement

- Oxleas NHS trust as a whole has a good record of staff engagement. Staff we spoke with did not feel very informed about wider issues affecting the trust but said “Directors do inform us about major things that happen but otherwise we don’t hear a lot from them.” Staff were

aware that information was made available in staff newsletters and on the intranet and said they were consulted on significant changes affecting the trust describing the consultation workshops and meetings organised for staff when ACHS were integrated within Oxleas NHS trust.

### Innovation, improvement and sustainability

- Staff said that managers were receptive to staff ideas and suggestions about improvements that could be made to working practices and we were given examples of projects that staff had suggested. For example staff told us about their suggestions which management had support to bring patients at risk of falls together so that information and education about preventing falls could be made available to more people.