Gloucestershire Care Services NHS Trust

R1J

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)
R1J01	Edward Jenner Court		

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

Summary of findings

Ratings

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

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Overall summary

Overall rating for this core service Requires Improvement l

- Gloucester Care Services NHS Trust provides community healthcare services for a population of around 605,000 people living in Gloucestershire. Adult community services cover approximately 1045 square miles in the Gloucestershire area. The care and treatment is provided under the regulated activities; diagnostic and screening procedures and treatment of disease, disorder or injury.
- We spent three days inspecting the adult community services provided, during which time we visited staff and patients in Gloucester, Tewkesbury, Forest of Dean, Stroud, Cheltenham and the Cotswolds. We spoke with a total of 95 members of staff and reviewed the following services: 6 integrated community teams which included community nurses, occupational therapists, and physiotherapists, homeless healthcare, diabetes specialist nursing, respiratory nursing, pulmonary rehabilitation, cardiac rehabilitation, telehealth, heart failure, rapid response, overnight nursing, speech and language therapy, endoscopy, outpatient's clinics, musculoskeletal physiotherapy, wheelchair services, ambulatory care centre, and the Kingham reablement unit. This was in addition to organised drop in sessions where staff were invited to come and speak with us regarding their role and the services provided. We spoke with13 patients and their relatives to seek their views of the service provided.
- During the inspection we looked at patient care documentation and associated records and observed care in patients' homes and in clinics and in a reablement centre. We reviewed meeting minutes, operational policies and staff records.
- We judged community health services for adults as requiring improvement in the safety domain. Shortage of experienced nursing and therapy staff left teams overstretched. Record keeping was inconsistent and omitted important risk assessments. This meant nursing staff did not always have a clear understanding of a patient's health status when giving treatment. Staff did not always complete a personalised care plan.
- Staff were not consistently following best practice in their approach to pressure ulcer wound assessment. This meant that deterioration or improvement in a wound might not be detected. In one location, medical supplies were stored above room temperature which meant that the effectiveness of the ingredients could not be guaranteed.
- Some equipment was shared between teams and staff had no record of when this equipment was last cleaned and serviced. Details regarding which patients had used this equipment were not traceable.
- Several of the staff in the community teams were out of date with their mandatory training; this was particularly noticeable in the overnight nursing team. Staff in the community adult teams were not required by the trust to complete the safeguarding awareness level 2 course. This contradicted guidelines produced by the Royal College of Paediatrics and Child Health. Board assurance of safeguarding could be strengthened.
- There was a clear incident reporting system in place, and learning was shared between teams. Community nursing staff had access to well serviced equipment and were able to access specialised equipment to meet patients' needs when required. The community service used effective hand hygiene procedures.
- The community health service for adults was effective. Teams worked together in a coordinated way and made appropriate referrals on to specialised services. The service participated in audits and developed action plans to improve. Staff gained consent for treatment and involved patients and relatives in decisions. Patients who were experiencing pain were helped to manage their pain. Staff used evidence based care informed by NICE guidelines. Telehealth services were used effectively to prevent hospital admission. A case management model was being used to address the needs of very complex patients at risk of hospital admission.
- Staff experienced some difficulties accessing information because the electronic record keeping system was not always available due to connectivity

Summary of findings

problems. Social care staff and health care staff used different patient record systems, which complicated the process of obtaining up to date information about patients.

- Healthcare staff tended to refer to other agencies when mental capacity required assessment. Supervision and appraisals of staff were not consistently completed.
- Patients received a caring service from staff that were kind and respectful towards them. Staff treated patients with dignity, involved patients and their families in their care and supported them during times of crisis. Staff gave clear explanations for treatment and encouraged patients to reach their goals.
- The community health services for adults were not always responsive. There were long waiting lists for occupational therapy and physiotherapy, both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment, and pulmonary rehabilitation. Waiting list data held by the trust was unreliable for the integrated community teams and for certain specialist services such as podiatry, the respiratory home oxygen service and the heart failure service.
- Staff considered the needs of people who may have difficulty accessing services and adapted their care approach to show respect for cultural factors. There was evidence of learning from the complaints received from patients and families.
- The community health service for adults was well led. There was a clear vision for the service. There were inspiring examples of innovation. This included the development of a health and social care complexity tool and some collaborative work with an industry provider in tissue viability services. Risk registers reflected the key areas of concern to frontline and management staff.

Summary of findings

Background to the service

Information about the service

- The community health service for adults provided services to a population of 605,000 people in both urban and rural areas. Services are provided in patients' homes, in residential and nursing home settings, in clinics, in reablement centres, and in community venues throughout Gloucestershire. There were six community integrated teams based in localities including Gloucester, Stroud, the Cotswolds, Tewkesbury, Forest of Dean and Cheltenham. Social care staff in these teams were employed by Gloucester County Council and were managed by Gloucester Community Services. In the near future management of social care staff will be transferred back to the county council. The integrated community teams include access to a rapid response service which provided a 24 hour seven day service to avoid hospital admission. Specialist services were countywide operating from various community locations.

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team of 34 included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community children's nurse, a palliative care nurse, a sexual health consultant and specialist sexual health nurse, a health visitor, a child safeguarding lead, a school nurse, directors of nursing, an ex-chief executive, a governance lead, registered nurses, community nurses and an expert by experience who had used services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services 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 23 – 26 June 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider say

- The trust had used the friends and families test to gain feedback about the quality of the community adult services. In April 2015, the response rate for the integrated community teams was low at 0.65% overall and 0.2% for community nursing teams. The response rate in May 2015 was worse with just seven responses recorded. The trust indicates that this data is not complete due to data capture problems associated with the roll out of the electronic record keeping system. In the specialist countywide services, the response rate was better, with 141 responses recorded in May 2015, with an average overall score of 9.07 meaning that 90.7% of respondents were extremely likely or likely to recommend the service to friends and family.
- We looked at feedback from Health watch. This is the independent consumer champion in health and care that gathers the views of people who use services. Feedback was mixed for occupational therapy and physiotherapy, but did identify long waits for physiotherapy appointments. For speech and language therapy, feedback was mostly negative, and centred on lack of contact. In podiatry, feedback was again mixed, praise given for a thorough and prompt service whilst in the clinic, negative feedback focussed on difficulty getting an appointment. For nursing, feedback was mixed, some patients and their families reported excellent service while others identified problems getting hold of nurses and poor communication between nursing staff.
- Patients and families who we spoke with during our onsite inspection told us that staff were caring and were always approachable.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST or SHOULD take to improve

- The provider should take action to address non-compliance with mandatory training and ensure that all managers have reliable systems in place for monitoring staff attendance at mandatory training
- The provider should take action to address waiting lists for therapies in the community health services for adults.
- The provider should ensure that medical and nursing supplies are stored in temperature controlled areas as detailed on manufacturer's instructions
- The provider should take further action to understand the shortfalls in recording of risk assessments and individualised care plans in the integrated community teams.
- The provider should strengthen the reporting on the assurance of effectiveness of safeguarding arrangements to the trust board.
- The provider should review the policy for mandatory training with reference to intercollegiate guidelines produced by the Royal College of Paediatrics and Child Health in relation to the safeguarding training requirements for nursing and therapy staff in the community health services for adults.

Action the provider COULD take to improve

Gloucestershire Care Services NHS Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

There was a shortage of experienced nursing and therapy staff in the integrated community teams. Nursing staff told us there was insufficient time to complete holistic assessments. Patient records were not completed in a consistent or thorough way and staff were unfamiliar with the use of the electronic record keeping system. We looked at 20 patient records. 50% of these records were missing an assessment to identify risk of malnourishment, malnutrition or obesity. 35% of the records were missing individualised care plans. 25% of the records were missing an assessment to identify risk of developing a pressure ulcer. Baseline recordings of patient observations were not always completed. This meant that nursing staff did not always have a clear understanding of a patient's health status when giving treatment.

Staff were not consistently following best practice in their approach to wound assessments. This meant that changes to wound presentation were less likely to be accurately recorded and deterioration may not have been addressed as readily.

In one location, medical supplies such as dressings and skin preparations were stored in a cupboard above room temperature which meant that the effectiveness of the ingredients could not be guaranteed. Some equipment such as a Doppler machine, bladder scanner and ear syringe were shared between teams and staff had no record of when this equipment was last cleaned and serviced, or an audit trail identifying which piece of equipment was used for which patient.

Several of the staff in the community teams were out of date with their mandatory training. This was particularly noticeable in the overnight nursing team where only 22.7% of staff were up to date with their safeguarding training. Staff in the community adult teams were not required by the trust to complete the safeguarding awareness level 2 course. This contradicted intercollegiate guidelines produced by the Royal College of Paediatrics and Child Health. Board assurance of safeguarding could be strengthened.

There was a clear incident reporting system in place, and learning was shared between teams. Community nursing staff had access to well service equipment and they were

able to access specialised equipment to meet patients' needs when required. The community service used effective hand hygiene and safety performance was improving.

Safety performance

- The general picture of harm free care in the community health services for adults had improved. The trust internal target for harm free care was 95%. This was measured by use of the NHS Safety Thermometer and included looking at the number of falls resulting in harm to the patient, the number of pressure ulcers acquired whilst in the care of the trust, the number of venous thromboembolisms and the number of urinary tract infections acquired by patients who had a catheter. In April 2015, all teams had met 95% target and in May 2015 five out of six teams met 95% target with Tewkesbury reporting 93.4%. The overall picture for harm free care was 94.9% compared to the national average of 94% in March 2015.
- During 2014-2015, the trust had a target to reduce the rate of acquired pressure ulcers to below 170. This figure was exceeded with a total of 119 pressure ulcers reported, of which 45 were acquired in community settings. Innovative work by the tissue viability team was aiming to simplify pressure wound management for community nursing staff through introduction of a mattress selection tool and a quick reference guide for the selection of wound dressings.

Incident reporting, learning and improvement

- Although the board risk register identified a low rate of incident reporting, there was a clear pathway of communication around incidents and learning from the incidents reported was evident.
- Whenever an incident was reported, the professional head and the trust incident leads were automatically notified via the electronic patient record keeping system. Tissue viability leads were notified of grade 3 or 4 pressure ulcers that were reported. Integrated community team managers were sent quarterly reports of incident trends, and the six integrated community team managers met fortnightly together with senior management to share learning between localities. Integrated community team managers met with their professional team leads to discuss incidents and then any learning was disseminated and discussed at team meetings. This feedback loop was not consistent in one outpatients department and had been raised as an issue with the incident reporting team.
- Staff felt able to raise concerns with their line managers and managers were heard encouraging staff to complete incident reports. Incident reports had appropriate action plans and included adherence to the duty of candour. The quality and performance committee report acknowledged that awareness of the duty of candour on the frontline of services may not be robust but staff we spoke with demonstrated understanding of this legislation.
- We saw evidence of learning being shared as a result of incidents being reported. When an incident report identified that nursing staff were assaulted in a care home for people with learning disability, training for staff was arranged and improved protocols were put in place. A trend in incidents in the respiratory service identified that the telehealth pod systems were becoming overheated during use. Action from the subsequent investigation resulted in patients being advised to turn equipment off overnight. In the overnight nursing team an incident occurred where staff had been unable to reach a patient who needed help with a catheter because staff were attending an urgent visit a long distance from where the patient lived. Learning focussed on changing the way that overnight nursing and rapid response teams worked together and the pooling of resources to meet patients' needs.
- Team meetings for the overnight nursing service were inconsistently attended and learning from events was cascaded via email. Managers recognised that there was a need to understand if this learning was embedding.

Safeguarding

- The trust was unable to provide detailed data regarding the uptake of safeguarding training or the level of safeguarding training completed in the integrated community teams or the specialist services. The trusts policy for mandatory training specified that nursing and therapy staff working with adults in the community were required to complete 'level one' safeguarding awareness training every three years, but were not required to complete more in depth training such as 'level two'. This contravened the guidelines published

by the Royal College of Paediatrics and Child health in March 2014. This recommends that level two is the minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers. Board assurance of safeguarding was limited to an annual report and quarterly safeguarding and performance dashboards.

- Staff knew who to refer to if a safeguarding concern arose though there was variable awareness of the safeguarding lead for the trust. Staff felt that the integration of the community teams had made access to advice for safeguarding much easier, although some concerns were raised regarding the need to check two systems of records to ensure up to date awareness of a patient's safeguarding status. We observed a case record where a safeguarding concern was raised on the county council system but had not been shared or recorded on the electronic patient record system.

Medicines

- We found that medicines were correctly stored and administered with one exception. In one surgery, medical supplies such as dressings and skin preparations were stored in a walk in cupboard under the eaves of the roof. There was no thermometer in use, but nurses acknowledged that this store was "always really hot", and the cooler outer room of the office registered at 27 degrees centigrade. When medical supplies are not stored within the temperature range identified in manufacturer's instructions, the active ingredients may become impaired and subsequent use of those supplies may be ineffectual, causing risk to patients needing active treatment.
- Community nursing staff were able to clearly describe the agreed protocol for administration of intravenous (IV) therapy via a peripherally inserted central catheter line and worked in conjunction with the IV therapy countywide team to an agreed care plan. The IV therapy team administered the first dose and then if necessary could be called to administer subsequent doses if the district nursing team could not reach the patient within the specified time frame, thereby ensuring that best practice was adhered to. We observed nurses administering medication via a subcutaneous syringe driver following best practice in medicines management.
- On home visits, staff checked that patients were adhering to new medication regimes. At the Kingham reablement Unit, patients administered their own medications with the help of compliance aids and telecare. This was overseen by a pharmacist who attended a weekly case review at the unit. One patient explained how staff had enabled them to develop their independence in managing their own medications prior to discharge home.

Environment and equipment

- Staff reported no difficulties accessing nursing and rehabilitative equipment for patients in their own homes. There was an integrated community equipment services team that provided governance and assurance for clinicians regarding equipment issues. The electronic system for ordering equipment ensured a quick response and a clear audit trail. Teams were kept updated regarding any new equipment available. Teams considered the need for bespoke specialist equipment such as in-bed sleep systems and complex equipment such as profiling beds to enable patient's independence. There was a comprehensive system in place for servicing of beds and hoists and wheelchairs.
- Some clinical equipment such as a bladder scanner, a 'Doppler' machine which measures blood flow velocities through arteries and ear syringe were shared between teams. This equipment was used regularly and there was no audit trail for cleaning and servicing and specific patient use of this equipment.
- We checked equipment stores and found that all equipment had been recently serviced and was stored correctly. We visited the endoscopy unit at Stroud Hospital. We were satisfied with the process of decontamination being used. Clinical equipment was traceable using a scanning process, a traceability sticker and a diary. Cleaning machines were tested daily for compatibility and the printed results were attached to the diary for future reference. Hazardous cleaning products were kept in a cupboard in a locked, well ventilated room.
- Nursing staff had recently been issued with new sphygmometers, tympanic thermometers, pulse oximeters and electronic blood pressure monitors with rucksacks to transport this equipment. Physiotherapists in the integrated care teams were looking to secure

funding for provision of pulse oximeters. Nurses were waiting for provision of weighing scales and in the interim relied on the use of patients own scales to complete important assessments such as Malnutrition Universal Screening Tool which identifies patients who are at risk of malnourishment, malnutrition or obesity.

Quality of records

- We checked 20 patient records on the electronic patient record system. We found that 50% of these records were missing an assessment to identify risk of malnourishment, malnutrition or obesity. 25% of the records were missing an assessment to identify risk of developing a pressure ulcer. Important data such as recordings of blood pressure, temperature, pulse oximetry and past medical history were sometimes missing. These omissions meant that staff did not have an accurate baseline recorded from which to measure future changes in patients' health status and to inform decisions about subsequent care. A professional team lead confirmed that all records should include a note of presenting complaints, allergies, medications, medical history, mental capacity, a 'Braden' assessment which measures the risk of breakdown to a person's skin, a 'MUST' which measures the risk of malnutrition, and a full set of clinical observations as a baseline.
- Nursing staff acknowledged that documentation of patient care had not been as thorough since implementation of the electronic patient record system. In the 20 patient records we checked, 35% of records were missing individualised care plans. This meant that there was no clear reference document that communicated the specific care needs of the individual patient. One patient expressed concern that wound management plans were not available in her home and "nurses did not know which dressings to use". Staff told us that the standard care plan on the electronic patient record system was inadequate. They knew there was a way to input more personalised care plans but were unsure how to do this. Their lack of familiarity with the system, particularly the assessment templates, resulted in staff 'free-texting' onto the continuation sheet and relying on the information inputted by the previous nurse to determine the care plan for their visit.
- In clinic settings, staff used laptops to record assessments during the patient appointment. Some community staff were reluctant to use laptops in patients' homes as they felt it interfered with their rapport. On several visits we observed staff experiencing problems with connectivity to the internet. This delayed and interrupted their input of records onto the system and lengthened the time needed to complete record keeping duties. The requirement to work 'offline' in some geographical areas caused nurses concern as the view on their laptop screens was not the same as the 'live' interface and was not familiar.
- A series of record keeping audits had been completed by the trust in the following clinical specialisms: respiratory and pulmonary rehabilitation, telehealth, podiatry, wheelchair services, cardiac rehabilitation, speech and language therapy, and bone health. These audits highlighted omissions of short and long term goals, treatment plans, informed consent, mental capacity assessments and information given to carers and relatives.
- The annual governance statement acknowledged 'gaps/ inconsistencies in record keeping'. This risk had been identified by the clinical commissioning group. Managers recognised that staff may be taking short cuts in documentation due to difficulties navigating their way around the electronic patient record system. Staff expressed that they would benefit from further training in the use of the electronic patient record system, particularly if this was clinically focussed. A professional team leader was tasked with putting in measures that would ensure that the electronic patient record system was clinically focussed and user friendly, such as including a RAG rating for assessments that need to be completed first. A clinical systems training programme had been developed to help new starters to use the electronic record system and this included a comprehensive library of quick guides and electronic demonstrations.

Cleanliness, infection control and hygiene

- We attended home visits, clinics and education classes. In all settings staff used techniques to prevent spread of infection including hand-washing, use of antibacterial hand gel and use of personal protective equipment such as gloves and aprons. Nursing staff disposed of infected clinical waste in identified bins which were collected from the patient's home. We observed diligent

infection control practice in the nursing care of a patient who had a peripherally inserted central catheter line in place. There was a countywide infection control team which could be contacted for advice.

- Infection control audits were not undertaken in the community settings. In one outpatient department wooden toys were used in the children's play area which posed a risk to infection control. In another outpatient department, patient toilets were not clean.

Mandatory training

- Poor compliance in mandatory training impacted upon the safety of the community health services for adults. This training was essential for safe and efficient functioning of health care organisations, patient safety and for the safety of each member of staff.
- In April 2015, compliance with mandatory training for both integrated community teams and specialist services was lower than the countywide figures for all courses. In April 2015, the integrated community teams training rates were all below 92%, with information governance at 66.4 %, fire safety at 71.6%, and conflict resolution at 82.86%, equality and diversity at 80.8% and health, safety and welfare at 91.9%. In April 2015 specialist nursing training rates were all below 94%, with information governance at 72.8 %, fire safety at 79.4%, conflict resolution at 83.7%, equality and diversity at 91.3% and health, safety and welfare at 93.5%.
- For the overnight nursing service, uptake of mandatory training was poor, with information governance at 40.9%, fire safety at 40.9%, conflict resolution at 36.4%, equality and diversity at 59.1%, health and safety at 63.6%, and safeguarding at 22.7%. The tissue viability team were up to date with their mandatory training.
- A member of staff facilitating the cardiac rehabilitation class was not up to date with their resuscitation training because the training had been cancelled on two occasions. Managers acknowledged that mandatory training was sometimes cancelled when service demands increased.
- It was recognised by the board that the trust was underperforming with regard to mandatory training. This risk had been identified by the clinical commissioning group. We were not told of any local action plans to address the shortfall in mandatory training.

Assessing and responding to patient risk

- Nursing staff were not consistent in their approach to pressure ulcer wound assessment. The National Institute of Health and Care Excellence (NICE) guidelines recommend use of a validated measurement tool such as photography or transparency tracing when assessing wounds. This is because repeat views of a wound can be compared objectively over time. Guidelines used by the trust gave clear instructions regarding use of photography. These guidelines prohibited use of personal cameras and mobile telephones but did not include guidance around availability of approved cameras. Nurses we spoke with were not aware of these guidelines. Cameras had started to be available as part of a pilot in wound photography, but awareness of this resource was not evident throughout the teams. Although the electronic patient record system did allow for photographs to be uploaded onto wound care plans, these were not evident in the majority of records that we checked. This meant that changes to wound presentation were less likely to be accurately recorded and deterioration may not have been identified.
- Due to inconsistencies in record keeping, teams did not always have a clear overview of the patient's medical status over time. This is important when managing patients with complex pathologies in community settings who are at risk of deterioration. Professional team leads acknowledged that the nursing approach to the completion of risk assessments was more systematic when records were paper based. They advised that holistic nursing assessments in the community could take three visits to complete, the first taking up to one and a half hours when baseline assessments were completed. We saw examples of nurses carrying out baseline assessments such as measurement of temperature, blood pressure, pulse and oxygen saturation levels, but our review of case records found that these were not consistently recorded, and important assessment tools which

monitor nutrition and skin integrity were not consistently completed. This was verbally confirmed by a professional team lead that had completed some informal checks of records.

- In a cardiac rehabilitation class, patients' blood pressure and pulse were checked at the beginning of the class and prior to exercise and one to one discussions ensured that staff were aware of any changes in the patient's condition between classes.
- Occupational therapy staff undertook moving and handling assessments in patient's homes in order to mitigate the risk of injury to patients and carers through unsafe handling or ineffective transfer technique. Therapists had support from countywide moving and handling advisors. Although occupational therapy assistants carried out assessments, they were aware of their limitations and complex moving and handling situations were assessed by qualified staff.

Staffing levels and caseload

- Teams were experiencing recruitment challenges, especially band 6 nurses. In March 2015 the funded establishment for all staff in the integrated community teams was 550.9 whole time equivalent. In April 2015, 492.4 whole time equivalent staff were in post, leaving a vacancy total of 58.5 whole time equivalent staff, not taking into account those staff who were appointed but not yet commenced employment. In Tewkesbury, the service had only 56% of its funded establishment for band 6 nurses in post. In January 2015, one band 6 nurse was covering seven band 6 posts across the Tewkesbury locality. The overnight nurses had a 26.6% overall vacancy rate, with band 6 nurse vacancies at 35.9%. Changes to shift patterns in the integrated community teams had resulted in many staff leaving and existing staff resource were being utilised over longer shift parameters. A recent recruitment day had yielded only one attendee.
- Band 5 nurses had been over recruited and these were scheduled to attend the specialist practitioner qualification with Gloucester University to bring their skills up to band 6 level. Some staff had been acting up to band 6 posts. Work had also focussed on improving the skills of unqualified staff to relieve the workload of band 5 staff.
- Nurses in the integrated community teams reported that they did not always have time to complete holistic assessments and home visits were often task focussed for this reason. The constant focus on completing visits left them little time to reflect on practice. Feedback from Healthwatch indicated that patients felt the community nursing service was overstretched for both daytime and overnight nursing shifts.
- There was no caseload management tool in use. There was no tool in use to measure acuity or dependency of patients in the community. The integrated community teams were developing a process to review caseloads but this was not yet implemented. This meant that management did not have detailed oversight of the demands on staff and the capacity available in teams. The board risk register identified: community nursing staffing pressures, increasing demand for the overnight community service from rapid response, demand for specialist services and vacancies in occupational therapy and physiotherapy. A draft district nursing action plan identified several measures to address recruitment and retention.

Managing anticipated risks

- Staff were aware of the new lone working policy and used this consistently. In a team meeting, practical issues with the policy were discussed and resolved. Overnight nursing and rapid response teams had access to a fleet of 4x4 vehicles and assistant staff were available to share driving at night times.
- Capacity in the integrated community teams was stretched over the winter, with particular pressure on reablement and social care staff in terms of quantity and complexity of patients seen. Rapid response teams helped to discharge patients from accident and emergency by proactively liaising with staff and providing urgent care services in the patient's home. Staff covered between localities to relieve pressures and agency staff were utilised. It was hoped that the development of a caseload management tool would ease future management of winter pressures.

Major incident awareness and training

- There was a new model for the business continuity plan regarding major incidents. It identified key contact details and a general pathway but managers had

Requires improvement

Are services safe?

identified that more detailed 'action plans' were needed to specify protocol for scenarios such as bad weather, flooding. These were currently under development. There was a 24 hour on-call rota for senior managers.

Good

Are services effective?

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

Summary

The community health service for adults provided care that achieved good outcomes, and was based on the best available evidence. Staff used NICE guidelines to inform their decisions about care and treatment. Staff gained consent for treatment and involved patients and relatives in decisions.

Teams worked together in a coordinated way and made appropriate referrals on to specialised services to ensure that patients' needs were met. The service participated in audits and developed action plans to make improvements. Patients were given a choice of options to manage their pain. A case management model was being used to address the needs of very complex patients at risk of hospital admission.

Telehealth services were used effectively to prevent hospital admission and telecare was used to support patients in their own homes.

There were difficulties accessing information about patients on the electronic record keeping system because internet connectivity was not always available, particularly in rural areas.

Social care staff and health care staff used different patient record systems which complicated the process of obtaining up to date information and important alerts at the point of referral. For mental capacity assessments, healthcare staff tended to refer to social care and mental health colleagues for advice. Supervision and appraisals of staff were not consistently completed.

Evidence based care and treatment

- We saw evidence of holistic assessment and treatment following best practice and incorporation of NICE guidelines. The electronic patient record keeping system included tabs which linked the user to clinical guidelines. These were attached to the assessment templates and were based upon best practice and NICE guidelines. Therapy staff had reviewed the NICE guidelines for falls as part of a peer development opportunity. As a result, exercise classes were designed to conform to best practice in falls prevention. The heart failure nurse had produced referral guidelines for the service plus a patient information booklet which were both based upon NICE guidelines.
- Staff were observed carrying out caring and holistic assessments, particularly with patients who had complex needs. Nursing staff had begun to use the Rockwood Clinical Frailty Scale which is a measure that can be used to predict the future dependence levels of patients. On a home visit, the rapid response team were observed to complete a thorough review, including comprehensive baseline recordings, nutritional intake, respiratory assessment, clinical assessment for urinary tract infection and chest infection, compliance with medication regime and checked arrangements for delivery of equipment. The homeless health team completed holistic assessments that included consideration of vision, mobility, prescribed and non-prescribed medication, domestic violence, sex abuse, chronic conditions, mental health and alcohol misuse.
- Implementation of NICE guidelines was discussed at clinical senate meetings and senior staff were encouraged to highlight on the risk register any areas where NICE guideline compliance was an issue. The podiatry service was non-compliant with NICE guidelines QS6 Diabetes in Adults due to lack of a Foot Protection Team. This was identified on the countywide risk register and an action plan was in place.

Pain relief

- We saw examples of pain relief being considered during home visits, in reablement settings and the gold standards framework meeting and complex care review meetings. We observed a home visit with a palliative care patient where options for pain relief were discussed with the patient and their family. We observed a home visit where a patient's self-management of pain was considered and therapy goals were adjusted to accommodate their pain control. In a referral centre

meeting, professionals discussed options for pain relief including use of a patch to enable a patient to have more sustained relief from pain which would facilitate their independence in activities of daily living.

Nutrition and hydration

- Staff ensured that patients were adequately fed and hydrated during their treatment sessions. In cardiac rehabilitation, patients were frequently offered refreshments during their class. On home visits staff offered food and made drinks for patients. At the Kingham Reablement Unit patients were encouraged to make their own breakfast and hot drinks in a communal kitchen. In this way patients were able to make choices and regain the skills needed to manage their nutrition and hydration needs post discharge.

Technology and telemedicine

- The specialist respiratory telehealth service aimed to prevent hospital admission using a teleconferencing system which was available for patients with chronic obstructive pulmonary disease or brittle asthma. During April 2015, 59 patients were using telehealth. Use of this system avoided the need for four patients to be admitted to hospital. Information was collated via a tablet device. Patients used a decision tree and specific questions triggered alerts to the respiratory nurse. The system was colour coded and available in different languages. Nurses were available during office hours with back up from the out of hour's service outside of these times. Telehealth calls were structured using a written prompt sheet that signposted clinicians to required actions. Faulty equipment was replaced within 3-5 days. Feedback from Healthwatch was positive: "it's brilliant for peace of mind and not having to bother the surgery"
- Telecare support and assistance was provided at a distance by means of sensors. Between March 2015 and May 2015, 272 patients began to use telecare, 203 of these were managed within the integrated community teams and 69 by the countywide specialist service. Gloucestershire Stop Smoking offered an online advice service as an option for service users wanting to access support to quit smoking. There was no telemedicine used in this trust.

Patient outcomes

- The clinical commissioning group confirmed that all targets set by the commissioning for quality and innovation framework's for 2014-5 were completed. The stop smoking service exceeded its target of 2332 for 2014/15 by 150 patients. This service was on track to meet the target for the first quarter of 2015, currently 163 towards a target of 615 by end of September.
- The integrated community teams took part in the National Audit of Intermediate Care, which enabled the trust to benchmark reablement services against over 200 similar services. The audit focussed on home based intermediate care and reablement. Actions focussed on improving access to mental health services, gaining a better understanding of outcomes and raising the profile of the Friends and Family test. The Trust had also participated in the National diabetes foot care audit and the National COPD audit and were awaiting these results.
- Several audits had been undertaken that monitored how responsive the services were. An audit completed in 2013 in podiatry concluded that inappropriate referrals were being received. This led to the introduction of a telephone triage system in April 2015 which has reduced the waiting list for podiatry. The specialist respiratory service conducted three monthly audits of visits, phone calls and the functioning of equipment. The new diabetes programme was audited in March 2015. NICE guideline 87 informed the criteria for the audit which focussed on clinical outcomes and attendance rate.
- The electronic patient record keeping system had brought opportunities to the occupational therapy teams to input assessment documentation from the Canadian Occupational Performance Measure which is an evidence-based outcome measure designed to capture a client's self-perception of performance in everyday living. Physiotherapy had also embedded a clinical outcome measure within the system. A recent project was piloted between February and May 2015 which aimed to introduce the use of patient reported outcome measures within the community settings. This project included the publication of a bi-monthly newsletter to GP's that raised awareness of the outcomes of therapy interventions. The homeless health service has recently carried out a successful

project to try to reduce the prescribed dosage of diazepam to their clients. Areas of good practice were identified with an action plan for continual improvement.

- The joint health and social care policy for clinical record keeping indicated that there should be annual audits of record keeping with action plans available at 3 months post audit and these should be reviewed by the locality board after 6 months. Services with less than 70% compliance should be re-audited. Several audits of record keeping had been carried out, with similar themes becoming evident. For example, in telehealth the audit highlighted areas of record keeping compliance below 70% such as completion of demographic details, name of consultant, long and short term goals, treatment plans, consent to share information, actual or potential lack of mental capacity recorded, and treatment plans to manage capacity issues. The resulting action plan concluded that staff should use more structured format for recording patient contacts and that training in goal setting would be implemented. The electronic patient record keeping system template had been reviewed to ensure that mental capacity was appropriately recorded and informed consent was added to the pulmonary rehabilitation assessment template. In speech and language therapy compliance was below 70% for some demographic details, long and short term goals, treatment plans, evidence of consent to treatment and to share information, and all aspects of mental capacity documentation. The action plan did not address the poor compliance in recording of mental capacity issues.
- Future audits were proposed at the clinical governance meeting and then discussed at the allied health professional (AHP) senate. These included: the use of drug charts in rural areas planned for June 2015, workload management tools to aid capacity and flow in the integrated community teams planned for May 2015, and a record keeping audit to test compliance with policy. It was also planned to review the practical impact of the wider use of electronic patient record keeping system in September 2015.

Competent staff

- The trust was underperforming in relation to the quantity of appraisals completed. In February 2015 the trust wide compliance was 71.03% with a target of 80% by June 2015. Appraisal rates in the integrated community teams were below the countywide rates at 66.2% and for the specialist nursing teams this was 78.2%. In the Cheltenham integrated community team, 52.3% of appraisals were overdue. In the overnight nursing team, 68.2% of appraisals were overdue. Centralised collection and reporting of training data was not robust because information was held across a number of different systems.
- The quality of appraisals was not audited and the trust did not provide data regarding the numbers of staff that had attended appraisal training. One appraiser remarked that she did not prioritise completion of appraisals. Appraisals were completed incorporating the national knowledge and skills framework of competencies, however there was mixed response from staff regarding the usefulness of the process. An overnight nurse stated that even if training needs were identified, it was difficult to take time off to attend training.
- Clinical supervision of staff was inconsistent. The trust supervision policy stated that supervision should occur at regular intervals, and should be offered on a formal basis. Nurses reported supervision was adhoc, informal and infrequent. Managers acknowledged that clinical supervision for the nursing staff required further work. A recent audit of occupational therapy supervision concluded that supervision was not consistently delivered in line with current supervision policy. 29% of occupational therapy staff considered that they were not up to date with the continuing professional development expectations of the professional body. Only half of the occupational therapy staff had a supervision contract, 10% had received no supervision in the past year, and 24% had received supervision less frequently than 8 weekly.
- Band 5 physiotherapists were unable to complete a rotation through core specialties due to the separation of countywide services which included acute care into the integrated community teams. This meant that physiotherapists did not gain skills in core areas such as acute care and this affected retention and recruitment.
- There were some good examples of clinical training. Integrated community team therapy staff assisted with training of reablement workers. We saw clear specific guidance around treatment being given in written

format to therapy assistants. We observed a visit where a band 5 nurse was accompanied by a band 6 nurse with specialist skills in palliative care in order to share best practice and increase the skills of the less experienced member of staff. Professional team leads held monthly continuing professional development sessions focussed on learning needs identified in training needs analyses. Staff in specialist services were encouraged to attend specialist training such as clinical reasoning and nurse prescribing. Some nurses were trained in specialist skills such as IV therapy. All qualified allied health and nursing staff had up to date professional registration.

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary working was clearly evident in the integrated community teams. Nursing, therapy and social care staff were committed to working together to meet the individual needs of their patients.
- Each of the six localities was working toward more cohesive integration. Integration with social care teams was identified as a key theme from the 'Understanding You' events held by the Trust. Managers voiced concerns that the future separation of managerial responsibility or social care staff threatened the progress made to date in relation to integrated care planning. Nursing staff were sometimes based in different locations to therapy staff and this may have contributed to slower integration between these staff. Several staff remarked that integration between therapy and nursing staff was an on-going focus.
- A case management model was being trialled in Gloucester and Tewkesbury integrated community team locations. Case management is a tool that integrates services around the needs of the individual with long term conditions using targeted, proactive community based care, including G.P. services. Case management is used for patients who are very complex and/or high risk. Teams met regularly to discuss patients in crisis who were at risk of admission to hospital or residential/ nursing care. G.P's were invited to attend. In some meetings a nurse acted as their representative. Effective liaison with the G.P.'s was made difficult by the high number of surgeries covered. During the meeting, staff considered the need for referral for specialist equipment, mental capacity assessment, mental health assessment, and continence assessment.
- A care pathway is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes. In the community health services for adults, we saw care pathways being used effectively. Gold standard framework meetings were used to coordinate pathways of care for end of life patients. There were referral pathways for heart failure team from primary and secondary care. There were clear specific care pathways and referral pathways for the home oxygen service. Clinical care pathways offered by the rapid response team included: unwell adult, UTI, falls, chronic obstructive pulmonary disease, cellulitis, delirium, intravenous therapy, palliative care in crisis. These pathways provided clear guidance to practitioners to ensure the most effective treatment was offered in high risk situations. The rapid response team were able to access community hospital beds if admission was unavoidable.
- The Kingham reablement unit encouraged a 24 hour ethos of rehabilitation involving the whole care team. Therapy cover was available five days per week. All care workers were employed by a charity and were participating in competency based reablement training provided by therapy staff.

Referral, transfer, discharge and transition

- The community health service for adults worked closely with other services to promote a seamless journey for patients in their care. The community nursing teams attended the complex care discharge planning meeting at local hospitals. The rapid response service worked closely with the integrated discharge team at the accident and emergency department. Therapists from inpatient departments carried out initial reviews of patients following discharge from an inpatient setting. This enabled good continuity of care.
- Inpatient wards identified appropriate patients and informed the heart failure team of pending discharge date. This minimised delays to this specialised service. As patients neared the end of their life, specialist

services for conditions such as Parkinson's disease did not withdraw, instead they engaged with community nursing staff to ensure an integrated approach which met the patients' needs.

- The Kingham reablement unit was a jointly funded health and social care facility that provided intermediate care for patients to ease the transition from hospital to home or to prevent admission to hospital or residential care. The service operated within clear referral criteria and their average length of stay was 19 days with occupancy rate ranging from 60-70% in the summer, rising to 90% in the wintertime. Staff at the unit participated in a daily teleconference with inpatient care teams to facilitate discharges where possible, accepting up to 3 admissions per day.
- Teams referred to specialist services where appropriate for example, orthotics or mental health. In referral centres, teams were developing a resource model, building links with charities such as Help the Aged and making connections in local communities in order to aid smooth transitions from health and social care when treatment was complete.
- Handover to the overnight nursing team was less assured. There was no protocol for handover of care from day staff to overnight nursing teams, although a safe operative procedure was being written. Handover occurred through electronic patient record keeping system except if the patient was unknown to the team and in this instance a verbal telephone handover was expected.

Access to information

- The use of electronic patient record keeping system and difficulties with mobile working were identified as key themes from the 'Understanding You' events held by the Trust. Access to clinical information was problematic due to connectivity to electronic patient record keeping system and staffs unfamiliarity and discomfort with the use of technology in community environments.
- Connectivity for electronic patient record keeping system was unreliable in some areas, particularly in the Forest of Dean. This resulted in nurses being unable to update patients' records whilst in the home or needing to do this offline and then upload when within signal range. Staff explained that accessing electronic patient record keeping system in the car was difficult due to postural discomfort. This had been escalated to moving and handling advisors but no actions had been communicated. The overnight nursing staff covered a countywide service and picked up referrals when not in the locality of the base. Accessing information about that referral was problematic if a signal was not available. The board operational risk register identified that service user status alerts were not displayed on the mobile working module which posed a risk to staff working in the community. Lack of vision of the GP system meant nurses were unable to check recent medical intervention if they were not at base and were unable to forward plan their visit schedules to accommodate geographical distance.
- Access to information in the integrated community teams was complicated further by social care staff using a different information technology system. When referrals were triaged in the referral centre, coordinator staff opened both systems to track involvement of health and social care staff. Coordinators cut and pasted relevant information from one system to the other to ensure that necessary information was readily available to the integrated team. This method was cumbersome and time consuming. Different systems hindered the ability for healthcare staff to input vital information for panel decisions around care.
- Although information technology support for the use of electronic patient record keeping system was regarded as helpful, it was not available at evenings or weekends or bank holidays. Staff experienced difficulties navigating around the system and this resulted in an inconsistent approach to recording. Both managers and clinicians felt that more clinically focussed training was required.
- Some services had been using the electronic patient record keeping system for longer and were more enthusiastic about its benefits. We saw the system being used effectively in a physiotherapy clinic and a cardiac rehabilitation class to check previous records and to input new assessment results. Although some nurses were observed to not have medical information available to them on their visits, most nurses were based in GP surgeries where this information could be easily accessed.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Good

Are services effective?

- Nursing and therapy staff in the integrated community teams and specialist services showed awareness of the need for mental capacity assessments to take place but tended to refer to other clinicians such as the G.P, mental health teams or social workers to complete the assessments. An audit completed by the Wheelchair service highlighted that mental capacity was rarely assessed when decisions were made about choices of wheelchair.
- Managers confirmed that further training was required to ensure understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The trust were unable to provide data regarding staff completion of training in this subject. Community psychiatric nurses from a neighbouring social and mental healthcare trust had been seconded to social care teams and were available in the integrated community teams to provide advice and to support staff to develop confidence in the use of the mental capacity assessments. Therapy staff had arranged their own training as a peer development opportunity and Band 6 nurses had requested further training. In case review meetings, managers prompted the need for mental capacity to be considered and staff were prompted by electronic patient record keeping system to complete mental capacity assessments.
- Staff were observed explaining treatment plans and obtaining written and verbal consent for treatment. In meetings we heard examples of best practice consent protocol being followed. Nursing staff told us about a recent flu vaccination clinic where consent for some patients could not be fully assured. They delayed the vaccinations until all efforts had been made to contact family and G.P. to confirm consent. Mental health nurses supported the dementia link workers within the trust and had arranged a dementia awareness week in conjunction with the Alzheimer's society. This raised awareness of the particular consent considerations for this patient group.

Good

Are services caring?

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

Summary

Patients received a caring service from staff who were kind and respectful toward them. Both nursing and therapy staff treated patients with dignity, involved patients and their families in their care and supported them during times of crisis. Staff gave clear explanations for treatment and encouraged patients to reach their goals.

Compassionate care

- In all the care we observed, nursing and therapy staff showed respect for patients and their families and a commitment to promoting the dignity of patients. Cinderford district nursing team were recognised by the 'Celebrating You' awards, winning the 'caring 'category**.** The needs of patients with complex needs were considered with compassion.
- On home visits patients were given reassurance and clear explanations from nursing and therapy staff. In a cardiac rehabilitation class, patients were greeted by name and encouraged to share their concerns on a one to one basis. Feedback from Healthwatch described the staff at the outpatients department at Tewkesbury as kind, caring, polite, friendly and informative.
- In the Kingham reablement unit a physiotherapist stayed with a patient an extra 20 minutes to make sure the patient was comfortable and had pain relief, despite knowing she would be late to pick up her children from school. All the patients we spoke with in this unit were happy with their care.

Understanding and involvement of patients and those close to them

- Staff involved patients and carers in the planning of care during visits to patients in their own homes. Nursing staff empowered patients by giving information regarding their condition and their care plan. Therapy staff gave patients information to make informed decisions about options for assistive equipment in their homes. In an education class, staff checked patients understanding and provided clear explanations.
- At the Kingham reablement unit, patients and families were encouraged to be involved in the decision to commence the rehabilitation programme. Carers were encouraged to provide weekly input and to be part of the multidisciplinary meeting.
- The heart failure nurse copied patients into all letters sent and patients reported that this helped them to feel involved. The respiratory health team trained carers to use specialist telehealth monitoring equipment if the patient themselves found this too difficult. Feedback form the outpatient department at Tewkesbury reports that patients were kept informed and made to feel relaxed. The homeless healthcare team worker was recognised in the 'Celebrating You' awards winning the 'understanding you' category.

Emotional support

- Patients told us they felt listened to and that staff understood their needs. We observed a therapy visit where a patient with a debilitating illness was given emotional support. The respiratory telehealth service gave reassurance and an explanation of symptoms.
- Staff gave positive encouragement to focus on rehabilitation goals. One gentleman was referred to the integrated community team for a package of care to assist with washing and dressing. He was low in mood and he felt that he did not need to get washed and dressed because he was staying in bed all day. Staff identified that he wanted to be able to go out to his local fish and chip shop and together with the patient they agreed a programme of graded rehabilitation activities to help him to reach this goal. With encouragement, this was achieved. Carers were no longer required because his motivation to look after himself had returned.

Requires improvement

Are services responsive to people's needs?

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

Summary

The community health services for adults were not always planned and delivered in a way that met people's needs, particularly with regard to people being able to access the right care at the right time for non-urgent needs. There were very long waiting lists for occupational therapy and physiotherapy services both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment (MSKCAT), and pulmonary rehabilitation.

Waiting list data held by the Trust was unreliable for the integrated community teams and for certain specialist services such as podiatry, respiratory home oxygen service and heart failure service which meant that senior managerial oversight was unclear. Occupational therapists and physiotherapists did not work on the weekends and there was no plan to implement this.

Guidance regarding the use of interpreting services was not consistently followed.

Staff considered the needs of people who may have difficulty accessing services and adapted their care approach to show respect for cultural factors. There was evidence of learning from the complaints received from patients and families.

Planning and delivering services which meet people's needs

- Feedback from staff that used the specialist diabetes service identified that classes were too long and rates of non-attendance were high. To address this, staff had redesigned the 'Diabetes Education and Self-Management for On-going and Newly Diagnosed' programme, which specialised in helping people with type 2 diabetes to self-manage their condition effectively. They had produced their own patient education programme called 'Diabetes, Food and You' which met the criteria in NICE guidelines. However rates of non-attendance for the diabetes service remained high at 63.1%.
- The wheelchair service had introduced a 'choose and book' system which had reduced the rates of non-attendance to the clinic. The cardiac rehabilitation service worked with the acute trust and the local university to produce a training DVD for attendees which enabled patients to continue their education in the comfort of their homes.
- A patient receiving IV therapy from a community nurse told us that without this specialised service at home she would have to go into hospital and that would make her feel downhearted and depressed.
- The tissue viability service were setting up a leg ulcer clinic in response to increasing demand from community nursing service to assist with leg ulcer management. Initially there were to be two clinics, increasing in time to ten throughout the county. These would run alongside the acute care leg ulcer service.
- There were no plans in place to extend therapy hours to cover weekends or evenings. This limited the availability of services for patients of working age or families who wanted to be involved in patients care.

Equality and diversity

- In one location we were told that members of staff with knowledge of different languages were used to interpret information for clients whose first language was not English, particularly for Portuguese and Ukrainian patients. This practice may have resulted in details of the patients perspective being lost in translation and did not follow the trust guidance for use of interpreting services.
- The diabetes service had developed an innovative education project designed for black and minority ethnic groups in conjunction with representatives from these groups. The seminars were delivered at community venues, with separate sessions held for specific groups such as Sahara Senali, Asian elders, Asian ladies, Asian men, Eastern African, and African Caribbean. The content was agreed by participants and was open to family members as well as patients, and involved practical cooking sessions. This encouraged meaningful participation in action based learning relevant to the patient and their support network in a protected environment.

Requires improvement

Are services responsive to people's needs?

- Staff told us about complex care situations where religious and cultural considerations had informed their care plans including consideration of Ramadan, understanding of patients and families belief systems in relation to medication and pain control, awareness of prayer routines when planning visit times.

Meeting the needs of people in vulnerable circumstances

- For the integrated community teams, meeting the needs of people in very rural areas was a challenge. The teams worked closely with 'village agents' (employed by borough councils) who had a comprehensive knowledge of resources in the local area. The Tewkesbury integrated community team were based in the same building as police services and staff have developed good links which aided identification of people who needed help from either service. Managers recognised that more could be done to engage with 'hard to reach' groups of patients.
- The homeless health service saw approximately 40 people daily, providing access to services such as immunisation, vaccination, health promotion and screening, drug and alcohol advice, mental health advice, podiatry and family/child/women's/men's health and development. An outreach service was provided where staff worked in pairs in collaboration with religious organisations to make contact with people in vulnerable areas of the city. The Kingham reablement unit worked closely with voluntary organisations to find suitable accommodation for homeless patients.
- In a case management meeting, staff discussed the care needs of a relative who was living with dementia and caring for his wife whose need for assistance with moving and handling was extensive. Another relative who was caring for his partially sighted spouse had recently had a stroke and broken his hip. The needs of both these carers were considered with compassion.

Access to the right care at the right time

- Vacancies in occupational therapy and physiotherapy had led to long waiting lists for treatment. Provision of timely occupational therapy and physiotherapy is necessary to prevent falls, prevent deterioration in a patient's ability to mobilise and participate in functional activities, to promote independence and to manage long term conditions. Managers assured us that the nursing and therapy teams were meeting 24 hour targets for urgent visits, but data was not available to substantiate this.
- In the integrated community teams there were 590 patients waiting for an occupational therapy appointment; 121 at Stroud, 46 at Gloucester, 89 at Forest of Dean, 30 at Cotswolds, 220 at Cheltenham and 90 at Tewkesbury. The longest recorded wait was 19 weeks at Gloucester. Although data submitted for Cheltenham did not include duration of wait, staff told us that the waiting list dated back to January 2015.
- In the integrated community teams there were 435 patients waiting to see a physiotherapist; 122 at Stroud, 70 at Gloucester, 42 at Forest of Dean, 99 at Cotswolds, 57 at Cheltenham and 45 at Tewkesbury. The longest wait was 15 weeks at Gloucester. Progress had been made in the South Cotswolds team because physiotherapy was made available in the referral centres at the point of screening and triage. This had reduced the waiting list from 12 weeks to 2 weeks.
- Referral centres in integrated community teams were responsible for triaging referrals and allocating work that needed urgent completion to make people safe and/or prevent hospital admission. Some referral centres did this as soon as a referral arrived, but others had a once daily meeting which meant that an urgent referral may wait up to 24 hours for triage and allocation. Therapy services did not operate a seven day service, which meant urgent referrals requiring therapy may wait over two days for a response.
- For musculoskeletal physiotherapy, urgent referrals were seen within ten working days, but routine patients went onto a waiting list of which there were 97 patients waiting for an appointment. Staff felt that the introduction of self- referral for this service had increased the size of the waiting list. Rates of non-attendance for this service were high at 48.8%.
- In May 2015, the musculoskeletal clinical assessment and treatment service received 522 referrals. 351 patients were on the waiting list with the longest wait being 19 weeks. Routine appointments for the musculoskeletal clinical assessment and treatment

service should be seen within 4 weeks. The integrated quality and performance report identified that waiting times for this service were above trajectory and this was impacting upon referral to treatment targets.

- In May 2015, adult speech and language therapy service received 261 referrals, 95 patients were on the waiting list and the longest wait was 13-14 weeks, however 90% of referrals were seen within the eight week target time. The service held monthly operational meeting which considered sharing of referrals to ensure people are seen within targets.
- Pulmonary rehabilitation had 233 patients on their waiting list, the longest wait being 33 weeks. Some patients waiting had declined offers of earlier appointments. A business case was being written to present to the clinical commissioning group as demand outweighed commissioned specification. Rates of non-attendance for the whole of the respiratory service were high at 38.6%.
- Some services were more responsive. The rapid response team aimed for a senior clinician to assess a patient within one hour of referral to provide advanced health assessment, diagnosis and intervention for up to 48 hours to avoid unnecessary hospital admission. This included access to 'safe haven' beds and a night sitting service for deteriorating patients. Clinicians could refer directly to the emergency department for diagnostic tests. For urgent referrals, the respiratory service offered a response within 72 working hours, working in conjunction with the rapid response team.
- No patients had been waiting more than 8-9 weeks for the diabetes service since February 2015. The wheelchair service operated an electronic system to plan the workload and manage the waiting list. Patients waited approximately five weeks for an assessment, subsequent delivery of the wheelchair occurred within 24 hours or sooner if clinically justifiable. There was, however, a long waiting list for a rehabilitation engineer to make adaptions to wheelchairs, the next available appointments being in October 2015.
- Waiting list data provided by the trust for podiatry, respiratory home oxygen service and heart failure service was described by the trust as "subject to data quality issues requiring on-going validation" and could therefore not be used in this analysis. Managers of the integrated community teams advised that waiting list data held centrally by the trust was not reliable.

Learning from complaints and concerns

- When questioned, patients did not know how to make a complaint. No staff members were observed to explain the process for making complaints during their home visits or clinic appointments. The annual complaints report had been presented and discussed at a team meeting. The integrated community teams recorded 11 complaints between April 2014 and May 2015. Five of these related to clinical care, three related to communication and three related to staff attitude. Actions for these included provision of an explanation and apology to complainants. Oversight of data regarding complaints in the integrated community teams was complicated by the existence of separate systems for social care and health.
- When a patient made a complaint about lack of availability of a social care package, the integrated community team worked together with the complainant to provide rehabilitation at home which increased his independence and resulted in no care being required.
- Complaints were handled sensitively. In a team meeting, staff discussed a recent complaint and showed compassion when considering the perspective of the complainant and their family. The manager offered support to the member of staff concerned. Following a complaint from a patient who lived in a rural area, the rapid response team considered flexible arrangements with more local staff in order to resolve delays in administering of pain relief.
- The friend and families test was introduced in the community teams at the beginning of 2015. Managers recognised that response rates were low and staff were encouraged at team meetings to increase use of this feedback mechanism in order to inform future service provision.

Good

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

The leadership of the community health service for adults supported learning and innovation. There were inspiring examples of innovation including the development of a health and social care complexity tool and some collaborative work with an industry provider in tissue viability services. Management promoted an open and fair culture and were well respected at a local level. There was a clear vision for the service.

There was some disconnection evident between frontline staff and the board in terms of awareness of core values and strategy.

Risk registers reflected the key areas of concern to frontline and management staff. There was insufficient assurance around safeguarding at board level.

Service vision and strategy

- All managers we spoke with articulated a clear vision for their service. Sustained integration was key to the vision identified by the integrated community team managers. They spoke of the challenges of working with two commissioners as well as separate human resources and information technology departments but they maintained a clear focus on patient care as central to their plans.
- Following the move of the out of hour's service to the South West Ambulance Services Trust in March 2015, the overnight nursing team were without line management or clinical oversight for approximately 6 weeks. The overnight nursing team and the rapid response team were in the process of becoming an integrated service with the aim of providing seamless unscheduled care between 10.30pm and 8am. These services had different specifications and clinicians had different competencies and specialist skills. Managers had a clear understanding of the challenges ahead including requirements for clinical training, governance, and cultural shift in leadership.
- The introduction of electronic patient record keeping system occurred during a time when nursing staff vacancies were high. A quality impact assessment for the introduction of the electronic record keeping service (undated) predicted no negative impacts upon service delivery. This analysis did not match the evidence found during our inspection. At a local level, managers recognised that there were ongoing clinical risks associated with implementation of the electronic patient record keeping system.
- Most frontline staff we spoke with felt disengaged from the board. Managers were more connected but the trust values were not well known amongst frontline staff. The quality and performance report in May 2015 acknowledged that 'well led' was a challenge particularly in terms of staff not understanding trust wide strategy plans or governance structures.

Governance, risk management and quality measurement

- Managers submitted a monthly governance report to the professional head of nursing and attended a monthly clinical governance meeting. Managers showed awareness of risks on the integrated community team risk register and this was regularly reviewed to discuss and implement action plans. The risk registers included the key areas of concern as identified by frontline and management staff. Connectivity to the electronic patient record keeping system in the Forest of Dean was highlighted as posing a risk to management of caseloads and contemporaneous clinical documentation. An action plan was identified. The nursing staff pressures at Tewkesbury, Cheltenham and the Cotswolds were on the local risk register for integrated community teams. Action plans were in place, but one of these identified that the embedding of electronic patient record keeping system had mitigated some risk, which was contradictory to our findings on this inspection. The unfamiliarity in use of the electronic patient record keeping system by community nursing staff was on the countywide risk register as resulting in a potential risk of data loss and substandard clinical record keeping practices. No controls or action plan were recorded.

Good

Are services well-led?

- We visited a newly opened ambulatory care unit. The governance arrangements for the unit were still under development and there was a lack of clarity regarding anticipated staffing requirements or patient activity levels. A training needs analysis was under development.
- There was insufficient reporting on the assurance of safeguarding arrangements at board level. Safeguarding was reported in the quality and performance governance committee report and this included a quarterly safeguarding and performance dashboard. There was an annual safeguarding report but there was no evidence of interim reporting.

Leadership of this service

- Local leadership was praised by staff as visible, accessible and responsive. The presence of professional team leads and heads of profession for each discipline was widely viewed as positive and staff welcomed the opportunity to question and reflect on practice. Leadership events were publicised at team meetings and all staff encouraged to attend.
- To mitigate the risks associated with non-recruitment of band 6 nurses, plans were underway for overstaffed band 5 nurses to be up skilled to district nurse level. Band 2 and 3 nurses were currently working towards Qualification and Credit Framework level 2 and 3 in order to support the band 5 nurses with skilled tasks.
- Introduction of the allied health professional senate provided a link to the board for allied health professionals but there was no representation of therapies at board level. The current director of service delivery had a professional background in occupational therapy, but their designated role on the board did not refer to a specific therapy remit.

Culture within this service

- Managers showed a caring approach towards staff. All staff showed receptiveness to advice from their colleagues and were supportive of one another. The chief executive was viewed as having made a positive change to the culture of the organisation
- Provision of protected time for supervision is considered best practice in healthcare. Managers were not able to provide clear oversight of the frequency or quality of supervision of staff which raised concerns around the prioritisation of this support mechanism. Staff records in the integrated community teams showed inconsistencies in the recording of supervision. Professional team leaders were accountable for the implementation of the supervision policy. This policy stipulated that supervision should occur at regular intervals, be offered on a formal basis and recorded and evaluated systematically through audit to assess its impact on performance, risk management, governance and outcomes. Within occupational therapy a review of supervision had led to plans for a new framework for supervision which was yet to be implemented.
- Staff sickness levels were high at a twelve month average of 4.9% compared to a nationally set target of 3% and a national average of 4.24%. Sickness rates were identified on the board risk register. Sickness rates in the Cheltenham team were particularly high at 6.49%. Disempowerment and decreased morale were identified as key themes in the 'Understanding you' events held by the Trust.
- Management of performance in the integrated community teams was handled sensitively and systematically following informal performance plans prior to instigation of disciplinary procedures. Staff participated in return to work programmes following ill health. Creative solutions were sought such as a change of base that had enabled staff to continue employment whilst accommodating the symptoms of long term conditions. 'Lighten – up' was a 6 week stress management programme for staff which had been offered to staff in the integrated community teams.

Public engagement

- The Trust held an engagement event in March 2015 as part of its 'Your Care, Your Opinion' programme. This gathered opinions regarding how the trust should deliver next year's strategic priorities, such as ensuring the best quality musculoskeletal and podiatry services and enhancing the integrated community teams particularly in relation to dementia care. This event informed the assimilation of the Quality Account 2015-2016.
- The specialist respiratory service had involved patients in the selection of a provider of a new telehealth monitoring equipment to ensure that it would be user friendly.

Good

Are services well-led?

Staff engagement

- The 'Listening into Action' programme was having a positive effect. Poor communication from senior management and an over-reliance on email was a key theme identified in the 'Understanding you' listening events held by the Trust in March 2015. The chief executive hosted six 'Big Conversations' in May 2015 as part of the trust's commitment to year two of the Listening into Action programme. Staff gave positive reviews of these events. These conversations focussed on themes of culture, technology, communication and integration. As a result, several of the trust leaders at executive level were available on Twitter to make them more accessible to staff using social media.
- External care update sessions were held with staff from the integrated community teams and specialist services during January-March 2015. These events discussed the role of staff in delivering the future external care programme, identified good practice and changes that could be made.

Innovation, improvement and sustainability

- We saw examples of innovative practice. The rapid response team were developing a health and social care complexity tool which recorded levels of frailty, safeguarding concerns, medical status, social deprivation, hydration and nutrition, and falls. This tool was a quality outcome measure which would support the case management model and could be used to trigger escalation of the deteriorating patient.
- The lead nurse for the tissue viability service worked in collaboration with an industry partner in order to deliver a dedicated programme of educational support to reduce pressure ulcers. This included a mattress selection tool, a quick reference guide for the selection of wound dressings following the trusts formulary and a pressure ulcer classification system. This work was published in 'Community Wound Care' in December 2014.
- There were 14 queens nurses employed by the Trust, ten of these were community or district nurses. A Queens Nurse is someone who is committed to high standards of practice and patient-centred care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (2) (c) Care and treatment must be provided in a safe way for service users. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (c) ensuring that persons providing care or treatment to the service users have the qualifications, competence, skills and experience to do so safely. Levels of compliance for mandatory training were unacceptable and the trust did not have appropriate oversight or control over this.