Derby Hospitals NHS Foundation Trust

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Community health services for adults

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Derby Hospitals NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Derby Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of Derby Hospitals NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Derby Hospitals NHS Foundation Trust provided a range of community health services for adults in Derby City, including district nursing, intermediate care, specialist rehabilitation and early supported stroke discharge. Services were managed at London Road Community Hospital and delivered in a range of locations, including patients' own homes, the community hospital and community clinics. We visited several community clinics, met with staff, visited the rehabilitation centre at the community hospital and went on home visits with community nurses and therapists.

Staff did not always report patient safety incidents and the uptake of training on incident reporting was low in some teams. Staff received good feedback about incident investigations, but there was little sharing and learning across the service in order to improve practice.

District nursing teams, in particular, were under-staffed and taking on increasing workloads. Recruitment was not successful in filling vacancies, and teams were delivering far more activity than they were contracted for. Staffing shortfalls meant that nurses could not attend mandatory and other training. Although there were governance structures in place to monitor and manage risks, long-standing risks associated with district nursing staffing levels and demands on the service had not been reduced.

Staff felt well supported by their immediate line managers, but there was a lack of clarity about wider management structures and roles, and communication needed to improve. Community staff felt disconnected from the rest of the trust, and services tended to work in silos. Opportunities for sharing learning and engaging with other staff as part of community-wide services were not well established.

There were suitable arrangements for the prevention and control of infection, maintenance of the environment and equipment, and the safe management of medicines. However, staff working in the community were not always able to access current information about their patients' care and treatment plans.

Patients received compassionate and respectful care. Patients felt involved in making decisions about their care plans. Care and treatment were evidence based and staff monitored the quality of the service they provided with a range of outcome measures. Community health services for adults were delivered through effective multidisciplinary teams. Most staff we spoke with were passionate about their jobs and were proud of their work. There were a number of successful innovative community programmes taking place both in the trust and with partners in the local health and social care sector.

Summary of findings

Background to the service

Derby Hospitals NHS Foundation Trust provided both acute and community based health services to a population of over 600,000 people in and around South Derbyshire. Community services were part of the Community and Rehabilitation Business Unit within the Division of Integrated Care.

The trust provided a range of community health services for adults in Derby City, including district nursing, community matrons, intermediate care, community therapies, specialist rehabilitation and early supported stroke discharge. The services worked in partnership with patients, acute trust services and other local health and social care providers. Community health services for adults were co-ordinated and managed at London Road Community Hospital. Care was delivered in a range of locations including patients' own homes, London Road Community Hospital and community based clinics.

Our inspection team

Our inspection team was led by:

Chair: Jan Ditheridge, Chief Executive, Shropshire Community Health NHS Trust.

Team Leader: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included a CQC manager, two CQC inspectors, two specialist nurses, an occupational therapist and an expert by experience who was a carer of someone using community services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive 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 8, 9 and 10 December 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We also spoke with staff individually. We spoke with 46 members of staff including community nurses, district nurses, community matrons, matrons, clinical team leads, health care assistants, managers, call handlers, directors, radiographers, doctors, occupational therapists, a physiotherapist, escorts, porters and car park attendants. On community visits we met 14 patients and three carers. We observed how patients were being cared for and reviewed patients' care and treatment records.

Summary of findings

What people who use the provider say

We spoke with 14 patients and three relatives during our inspection. All of the people we spoke with told us their needs were being met and they praised the service they received. We were told that the community nursing service was very good and that staff were caring. One patient told us "I receive good care and I am happy with the service." Another patient said, "The nurses are fantastic, I don't know what I would do without them." Another person said, "They [the community nurses] can't do enough for me."

Good practice

Our inspection team highlighted the following areas of good practice:

- Patients were always placed at the centre of their care and were given choices which were listened to and acted upon.
- Staff we spoke with were positive about their role and the work they were doing, despite the resource difficulties they were experiencing.
- Staff were passionate and committed to providing a good standard of care for patients.
- There were a range of initiatives to ensure patients received the care they needed both to remain at home without hospital admission and to leave hospital with appropriate multi-disciplinary care in the community.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider must ensure that there are sufficient suitably qualified, skilled and experienced staff in the district nursing teams to meet the needs of people using the service, and to respond to changing circumstances in the service.
- The provider must ensure that staff visiting patients in their homes are able to access the complete information they need before providing care and treatment .
- The provider must ensure that all community health services for adults staff are able to attend mandatory training and other essential training as required by the needs of the service.
- The provider should support community and district nursing staff to report patient safety incidents appropriately and ensure they are able to access training in incident reporting on a regular basis.
- The provider should ensure that all community health services for adults staff are able to access appropriate one to one supervision on a regular basis.
- The provider should strengthen ways of learning from incidents and sharing good practice across the community health services for adults.
- The provider should ensure that staff in the community are supported to comply with the lone working policy in order to promote their safety.
- The provider should improve the monitoring of patients' concerns, comments and complaints so that they can be used systematically as an opportunity to learn.
- The provider should strengthen the engagement with community health services for adults staff, and improve communication about service design and strategy.
- The provider should monitor the use of interpreter services so as to ensure patients' individual needs are being addressed.

Derby Hospitals NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

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

Requires Improvement

Are community health services for adults safe?

By safe, we mean that people are protected from abuse

Summary

Staff did not always report patient safety incidents and the uptake of training on incident reporting was low in some teams. There had been investment into supporting staff in the community with managing and preventing the most common serious incident, pressure ulcers. Staff received good feedback about incident investigations, but there was little sharing and learning across the service in order to improve practice.

There were suitable arrangements for the prevention and control of infection, maintenance of the environment and equipment, and the safe management of medicines. People's personal and confidential information was stored securely. Staff working in the community caring for people at home were not always able to access electronically held current information about their patients' care and treatment plans, which meant they might not be fully prepared to care for a patient.

District nursing teams in particular were under-staffed and taking on increasing workloads. Recruitment was not successful in filling vacancies, and teams were delivering far more activity than contracted for. Intermediate care nurses and community matrons supported the district nursing teams, and all staff were dedicated to providing a good service for patients. Staffing shortfalls meant that nurses could not attend mandatory and other training, and did not always have time to complete incident reports. Staff did not always reduce risks to themselves by following lone working policies.

Incident reporting, learning and improvement

- Staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. However, we were not assured incidents were always reported correctly. We observed two incidents in people's homes, one

involving a potential missed medication and another involving potential risk to a child, where staff members took correct actions but did not consider it necessary to report the incidents.

- Clinical staff based in trust premises could easily access the electronic reporting system. Community nurses providing care in people's homes reported any incidents when they returned to their base, often at the end of a long shift of visits. Staff told us they did not always have the time to complete incident reports as they should. This was confirmed as a known risk in the minutes of a governance meeting in September 2014. Low staffing levels meant that team leaders were involved in patient care and were not able to devote time to incident reports. This meant risks to patients and staff were not fully monitored and there were lost opportunities to improve practice.
- Eighty four serious incidents were reported within community health services for adults between September 2013 and September 2014. All of these were pressure ulcers. Between April 2014 and November 2014 there were 56 reported pressure ulcers. A part-time team leader post had been created, focused on supporting district nursing teams to manage pressure ulcers. The team leader carried out all of the investigations using root cause analysis (RCA) methodology. This is a method of investigating something to get to the actual underlying reason/s that caused it to happen. The team leader liaised with the tissue viability team to ensure appropriate training was delivered to nurses and support workers. Between April 2014 and November 2014 there were 56 pressure ulcers, however, 52 of these were deemed following investigation to have been unavoidable. In September 2014, a review of pressure ulcer prevalence in the district nursing service was carried out. The review looked at the numbers of ulcers, outcomes from the investigations and the learning points that needed to be addressed. it also highlighted areas of good practice.
- There was a thorough RCA of each reported incident and the team leader took the final report to the trust's incident scrutiny group. They then presented feedback and explained required improvements at individual nursing team meetings.
- A review of the RCAs identified contributory factors and plans for improvement. These included training for all district nursing staff in tissue viability, and ensuring staff completed incident forms promptly in line with trust policy. The team leader told us the tissue viability training was now in place and most staff had completed it. It was also part of a competency framework that all community staff were required to complete. Training in incident reporting was also available, but less than half the staff had attended this.
- Staff received local feedback, as described, but there was little evidence of staff being involved in learning from incidents and sharing good practice across teams and departments. We reviewed the minutes of a range of team meetings. We rarely found any discussions of learning from incidents other than promoting improved reporting. 'Incident reporting, trends and priorities for action' was a standing agenda item at the community business unit monthly governance meetings, but in the two sets of minutes we reviewed from September and November 2014 there was only one recorded discussion about developing benchmarking for community pressure ulcer rates.

Duty of Candour

- NHS hospitals have a responsibility to inform patients when things have gone wrong and harm has been caused. Duty of Candour was discussed at the district nursing sister's weekly meetings before its implementation in November 2014. Minutes from their November meeting made reference to a leaflet developed for patients of the Duty of Candour in relation to pressure ulcers. A clinical team leader confirmed that the district nursing sister shared an information sheet with the patient and relevant family members to explain what had happened, along with a letter of apology.

Safeguarding

- Training in safeguarding adults and children was mandatory for all community staff. Trust data showed that community health services for adults staff were up to date with this training. The staff we spoke with all said they were confident in reporting safeguarding concerns. They were aware of the trust policies for safeguarding adults and children, and were able to describe the procedures to follow if abuse was suspected or alleged.
- Ninety seven per cent of community staff had completed safeguarding training. Only 60% of district

nursing staff were up to date with this training in October 2014, but this had increased to 75% in November 2014, although still falling short of the trust target of 80%.
- The trust provided three levels of safeguarding training to staff; awareness, standard and enhanced training. Data provided by the trust made it difficult to ascertain the level of safeguarding training staff had undertaken.

Medicines management

- There were systems in place to ensure the safe administration of medication in the community. The trust had an up-to-date medication policy for staff to follow and people had medication administration records within their home.
- Patients receiving care in the community kept their medicines at home in accordance with their own preferences and storage instructions. Community nurses reviewed patients' medicines with them when visiting them at home. This was to ensure people had not had any changes to their medication since they were last seen, to establish they were taking their medication as prescribed and ensure they had not experienced any side effects from their medication.
- Where necessary, people receiving care in their own home were issued with medication aids such as dossette boxes to assist them in identifying the correct medication to take. [Dossette boxes are individualised boxes containing medication organised into compartments by day and time].

Records and management

- Community staff completed electronic patient records using the trust's electronic reporting system. Some local GPs used the same electronic reporting system, which enabled information about patients' current care and treatment plans to be shared. Some community teams, however, were unable to access the electronic system. The rapid response team which visited patients in the evening were unable to access this system. This meant staff were not able to view the most current information about the people they were supporting.
- Patients' care records were paper based and kept in patients' homes. We reviewed six sets of patient records and found they contained the necessary information relating to care plans and risk assessments.
- Patient identifiable information was stored securely and electronic records were protected by password access.
- There were systems and protocols in place for sharing information with other professionals such as with GPs. Staff were aware of the requirements to maintain people's confidentiality at all times.
- Information governance training was mandatory and staff told us they were up-to-date with this training. Ninety-two per cent of community staff had completed information governance training against a target of 95%.

Cleanliness, infection control and hygiene

- All the staff we spoke with told us they had received infection control training, and trust data confirmed this.
- The clinics we visited were clean, well ordered and uncluttered. Staff working in the clinics and in the community complied with recognised guidance to reduce the risk of spreading infection. This included appropriate hand washing, using hand sanitising gel when out in the community, personal protective equipment, such as gloves and aprons and correct, and correct techniques for dressing wounds.
- We observed nursing and therapy staff during home visits. They showed good understanding and application of infection prevention and control. Staff wore clean uniforms with arms bare below the elbow in line with trust policy.
- Audits between April and June 2014 found that all staff demonstrated good hand hygiene techniques and aseptic non-touch techniques, which aim to prevent contamination of sites such as wounds or catheters

Mandatory training

- In December 2014, not all teams had met the expected levels of attending mandatory training (enhanced safeguarding, information governance and infection control). District nursing teams did not meet the trust target of 80% in two of the three areas.
- Various quality and performance reports recorded that low staffing levels in district nursing teams meant that staff could not be released to attend mandatory training.

Lone and remote working

- The trust had policies and procedures designed to protect staff when working alone or remotely. All community staff we spoke with were aware of the lone worker policy and the procedures that should be followed. However we found that due to staffing

pressures there were occasions when these policies were not followed. For example, community nurses told us there were times when some staff had not reported back to base when they had finished their visits.
- All community visits were risk assessed and where the level of risks indicated it was necessary, community staff worked in pairs or an escort was provided.

Assessing and responding to patient risk

- Clinical risk assessments were completed and followed for each patient. These included assessment for pressure ulcers, nutrition and mobility.
- The clinical team leads reported that workloads were prioritised using a traffic light system, visits were reviewed and patients were contacted to see if they still needed a district nurse to visit.
- Patients who were struggling with mobility problems, whose carers were not coping, or who had exacerbations of long term conditions were referred through the Single Point of Access (SPA). In August to November 2014, more than 90% were seen and assessed by appropriate members of the intermediate care or community teams within 24 hours.

Staffing levels and caseload

- District nursing teams had high levels of vacancies, sickness absence and maternity leave, and increasing workloads. Senior managers were fully aware of the undue pressure on district nursing staff.
- There were four community team leaders posts to support 15 district nursing teams, but only two people in post. District nurses (sisters) were reduced by 10% but true vacancies were in fact higher due to long term sickness and re-deployment. Community nurses (staff nurses) were carrying 10% vacancies and there were additional staff on or about to go on maternity leave. The evening service also had vacancies in both district and community nurse roles.
- The district nursing activity had been significantly over target since April 2013. In seven of the last 18 months, district nursing teams carried out more than twice as much work as scheduled for, and this was consistently the case for the evening district nursing service. Community nursing staff reported concerns about low staffing levels and the impact this was having on their workloads.
- The matron for district nursing reported high levels of sickness absence, including absence due to work-related stress, which had a wider emotional impact on the staff group. For the three months from September to November 2014, the sickness absence rate was more than 9%, significantly greater than the trust average of just under 4%.
- District nursing staff told us they rarely finished their shift on time and regularly worked more than their contracted hours to cover for absences. A community nurse told us that recently in one team there was only one qualified nurse on duty out of a team of five nurses and two support workers. Clinical team leaders told us that absences were filled with regular bank staff but this was not enough to fill the gaps. Part-time staff were offered additional hours and overtime, and intermediate care nurses and community matrons helped out. Team leaders worked clinically. Staff were concerned that the pressures were causing the quality of care to suffer
- Team leaders checked caseloads with the district nursing sisters every three months. Caseloads and staffing levels were calculated and monitored using a daily measurement analysis tool. This calculated staffing levels that were required and available as points according to patients' needs. A nurse told us they worked on a points system and should have 18 to 20 points per day. However it was always above 20 and had peaked at 35.
- In September 2014 the week day staffing required was 27% greater than staffing available, and in October 2014 this had risen to 38%. In September one team had no staffing capacity for three of the four weeks. In the last two weeks of October, seven out of the 15 district nursing teams had no staffing capacity.
- The analyses also identified visits which were purely to prompt people to take their medicines. Social care services had withdrawn from providing these visits and the responsibility had been picked up by the district nursing service. These visits varied across the localities and were not carried out by all teams, but some teams carried out more than 50 prompt visits per week. The weekly totals for each team were not aggregated to show the impact on staff capacity overall. In order to relieve this pressure, eight support workers had been recruited and would be working across the teams to take on this role.
- Some district nursing staff told us they were under pressure from GPs to provide services outside their remit, such as giving certain immunisations. In

September 2014, the Clinical Commissioning Group review found some nurses carrying out continuing healthcare assessments which should have been done by another agency.

- The analyses for weekend staff did not show staffing available, so it was not possible to determine the capacity issues.
- The general manager told us that, recently, there had been insufficient staff available at the weekend to deliver the work. Intermediate care nurses were able to help out.
- Senior managers had taken a number of actions, including continued recruitment efforts, setting up a staff health and wellbeing programme, daily prioritising of patients and escalation to the safe staffing board.
- The general manager told us they maintained a locality 'heat map' showing the current 'hot spots' of pressure on staff. We asked him where the current 'hot spots' were but he was unable to tell us. There was a danger that a situation that had been prevalent for so long had become 'the norm'. However, the matron for district nursing was tireless in her continued escalation of the risks.
- Other teams in the community health services for adults were carrying vacancies, such as the community matrons who had a vacancy rate of 12.5%. However staffing levels in the district nursing service were the highest risk, not least in the context of high demand on their service, in terms of patient complexity and numbers of visits.
- We observed a community nursing handover. This ensured that all staff in the team were aware of the needs of all patients within the team. Handover from the evening district nursing service to the night service (provided by another organisation) took place by fax machine. Evening district nurses did not have access to the trust's electronic reporting system and could therefore not update electronic records.

Managing anticipated risks

- Influenza (flu) vaccinations were offered to patients considered to need them. However information provided by the trust indicated there had been issues keeping up with flu vaccinations due to the levels of staff trained to administer them. The Matron for the service was in the process of quantifying the numbers of patients on the district nurse caseloads who had not had the flu vaccination.

Major incident awareness and training

- Community staff reported that major incident planning had not taken place and they had not received any specific training relating to major incidents. There were however, arrangements in place for staff to follow in severe weather conditions.

Good

Are community health services for adults effective?

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

Summary

Care and treatment were evidence based and staff followed current national guidance and best practice recommendations. Staff monitored the quality of the service they were providing through a range of outcome measures.

Community staff were appropriately qualified, skilled and competent to carry out their roles. District nursing staff did not all receive regular supervision sessions with their line managers and low staffing levels made providing patient care a priority over training. Therapists and nursing staff in clinics were qualified to the appropriate level and worked well to meet the needs of patients.

Community health services for adults were delivered through effective multidisciplinary teams, which linked with external mental health and social care providers. Some teams did not have access to patient information while carrying out home visits, and so were unable to review detailed and updated information about the patient and their condition.

Evidence based care and treatment

- Care and treatment were planned in a personalised and holistic way and care plans took into account people's social as well as health care needs.
- The trust had a range of policies and clinical guidelines for staff to follow in the care of common conditions such as the treatment of leg ulcers.
- Care and treatment were evidence based and staff followed best practice recommendations. For example, people who used the service had an assessment of their risk of developing pressure ulcers using a nationally recognised tool. This assessment tool takes into account practices that are necessary to prevent pressure ulcers as identified by the National Institute for Health and Care Excellence (NICE).
- Staff were able to access equipment for patients if their risk assessment indicated it was required. For example, if a patient's Waterlow score indicated that a pressure relieving mattress was required. The nurse assured us they would be able to order this equipment and it would be delivered in a timely manner.
- Nurses and therapists at the Specialist Assessment and Rehabilitation Centre (SpARC) carried out evidence based falls management and treatment of people with Parkinson's Disease. Senior staff were active in research in the field.

Pain relief

- Nursing and therapy staff completing home visits asked patients if they were in pain and they talked to them about their pain control medication and supported them to follow their pain management care plan.

Nutrition and hydration

- Staff completing home visits asked patients about their eating and drinking, and encouraged good nutrition.
- Patients' nutrition was assessed using the Malnutrition Universal Screening Tool (MUST) and patients were referred to a dietician or speech and language therapist when necessary.

Approach to monitoring quality and outcomes of care and treatment

- Staff monitored the quality of the service through a range of different outcome measures. Outcomes were monitored on a monthly basis and demonstrated positive outcomes for people using the service.
- Community nurses kept photographic evidence in patients' records of pressure ulcers and wounds, which meant they could monitor change.
- The intermediate care team used the Barthel Index scale to measure performance in activities of daily living. The outcome of care and treatment was measured by comparing the score on admission to and on discharge from the service.
- The early supported stroke discharge team used a number of outcome measures such as the stroke impact scale.
- In SpARC the falls team delivered an accredited weekly exercise based group, the Otago group, over eight weeks

(Otago is a series of seated and standing exercises adapted for all abilities. It is designed to improve your strength, balance and coordination, and help reduce your risk of falling).

- Patient outcomes were measured using the recognised Berg Balance Scale (BBS) and found improvements in the group attending between July and September 2014. The BBS was developed to measure balance among older people with impairment in balance function by assessing their performance of functional tasks). The Parkinson's Disease team used a variety of manual skills to assess handwriting dexterity following an occupational therapy-led seven week course. Patients showed improvement and also reported perceived improvements in their handwriting.
- The trust reported that they took part in the national benchmarking programmes for intermediate care (in 2013 and 2014) and district nursing (in 2014) but did not provide us with the outcomes of these programmes and we were unable to find any results.

Competent staff

- Staff received an induction on starting employment with the trust. Appraisal rates were good and nearly all community staff had received an appraisal in the last year. An appraisal provides staff with the opportunity to receive feedback on their progress, set objectives for the coming year and identify learning and development needs.
- All of the patients we spoke with in clinics and in the community were complementary about the ability of community staff.
- Community matrons were competent to prescribe and met regularly for professional peer support and development. Therapists and nursing staff in clinics were qualified and registered in their professional field and worked well to meet the needs of patients.
- Community therapists and district nursing staff had nearly all completed tissue viability training to help them manage and prevent pressure ulcers in the community.
- Most staff told us they felt well supported by their immediate managers but community nurses told us they were not having regular one-to-one supervision meetings with their managers. This was confirmed by the workload management tool. This meant that staff may not always have the opportunity to raise their concerns, identify training and gain individual support from their manager.
- Community nurses were supported to take up district nurse training. At the time of our inspection there were six community nurses taking the course, with four due to qualify in 2015. The matron told us there would be positions as district nurses for all of them.
- While some of the community nursing staff told us they were supported to attend training, and community therapists said the department was proactive in supporting professional development, some therapists told us it was difficult to get funding for courses and conferences. They also said training courses, booked through the National Centre of Rehabilitation Education (NCORE) were often cancelled. One therapist told us they had booked onto three courses this year, all of which were cancelled. Out of 119 courses arranged by NCORE between 1 April 2014 and the time of our inspection, 23 (nearly 20%) were cancelled, mainly due to insufficient uptake.

Multi-disciplinary working and coordination of care pathways

- Staff told us there was good team working between all professions and grades of staff.
- We saw evidence of effective multi-disciplinary team working. For example we spent some time in the community with a patient who had experienced a stroke. We saw that in addition to the community nursing team, this patient also received coordinated care from physiotherapists, dietician and speech and language therapists.
- The Single Point of Access (SPA) was available for GPs and health professionals to refer frail elderly patients so that care was coordinated and patients received the right community assessments and care within two hours if necessary. The multi-disciplinary services included mental health and social care services.
- The rapid response team comprised nurses, clinical support workers, therapists and administration staff. The team worked to prevent people being admitted into hospital or having to go into a care home, by supporting them to regain their independence.
- SpARC delivered multidisciplinary assessment and treatment to patients with Parkinson's Disease and other long term conditions, and those who have

suffered falls. Following initial assessment by a consultant, patients were seen by a nurse, physiotherapist and occupational therapist. Staff compiled a personalised care plan and provided on-going treatment and support according to individual needs. Staff arranged speech and language therapy appointments for patients where appropriate.
- The SpARC provided a range of services, clinics and support groups including anxiety management for falls patients, Parkinson's education and support groups, and Tai Chi.

Availability of information

- Community staff were unable to access the electronic records system while on visits. Evening district nurses and community staff were not able to access the system at all. This meant that staff were unable to view the most up-to-date information about patients while they undertook their visits.
- All patients receiving care in the community had care plans available in their homes.
- Staff told us they could provide patients with information leaflets about health conditions and available services in a variety of languages and formats.

Consent

- Staff demonstrated confidence in seeking valid consent to treatment from patients. They explained things to patients in a way that they could understand and helped them make informed decisions.
- Staff were aware of their responsibilities in relation to patients who lacked the capacity to make decisions about care or treatment, in line with the Mental Capacity Act (2005). Staff knew the procedures to follow to involve other professionals and relatives in reaching decisions in patients' best interests.

Good

Are community health services for adults caring?

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

Summary

Patients received compassionate and respectful care. Community staff discussed planned care and treatment with patients and provided information to support patients' understanding. Patients told us they felt involved in making choices and decisions about their care and treatment. Staff provided emotional support for patients and their carers.

Dignity, respect and compassionate care

- People who received community health services for adults were treated with compassion, dignity and respect. All of the people we spoke with were positive about the care they received.
- In the community, nursing and therapy staff tried to ensure a patient's visits were carried out by the same staff member to establish continuity of care.
- All staff asked permission to enter patients' homes before going in.
- We observed good rapport between staff and patients and their carers. For example we observed supportive and respectful interaction when a staff member worked with a patient with profound learning and physical disabilities.
- Staff always asked patients for consent and spoke with them with in a respectful way before they carried out assessments or provided care and treatment.

Patient understanding and involvement

- Patients told us they felt involved in making choices and informed decisions about their care and treatment.
- We saw that staff discussed planned care and treatment with patients and where necessary provided information to reinforce understanding. We saw a community nurse taking great care to ensure the patient and their relative understood what was going to happen before administering the treatment.

Emotional support

- Community staff considered emotional support as part of their assessment and could refer to appropriate support services where appropriate.
- SpARC ran well-attended educational groups for people with Parkinson's Disease and their carers, covering the emotional aspects of living with the condition. Therapy staff provided patients with information about local groups and support organisations.
- All staff we spoke with told us that part of their job was to provide emotional support for patients and also their families and carers.
- Staff completing home visits demonstrated knowledge of patients and their unique situations. We saw that appropriate emotional support was provided.

Promotion of self-care

- People were supported to manage their own health and care and maintain their independence. For example, we accompanied a district nurse on one of their visits. The patient required an injection. The nurse gave the patient the choice of learning how to administer the injection for themselves.
- Therapists working at SpARC focused on supporting patients to manage their condition at home and maintain their independence. They provided patients with ongoing support by telephone consultation, so as to avoid hospital appointments and they provided rapid assessments for deteriorating patients that could be arranged within 48 hours.

Good

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

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

Summary

Community health services for adults were responsive to people's needs. All of the patients we spoke with confirmed their healthcare needs were being met and were full of praise for the service they received. There were a range of initiatives to ensure patients received the care they needed both to remain at home without hospital admission and to leave hospital swiftly with appropriate multi-disciplinary care in the community. Referrals to the district nursing service were managed separately and not as effectively as the clinically led single point of access for intermediate care services. Staff could access interpreters for patients whose first language was not English, but the service did not monitor the use of interpreters and community staff reported practical difficulties which had not been addressed. Patients' concerns, comments and complaints were not used systematically as an opportunity to learn.

Planning and delivering services which meet people's needs

- Community health services for adults delivered person-centred care and treatment, aimed at supporting people to remain independent in their own homes. Services also supported patients' carers and relatives, taking into account people's holistic needs.
- The lead commissioner of services at the trust set local quality improvement goals, known as CQUINs. Consistent performance information for community services for adults was only available for April through to June 2014. The trust had met targets to improve care and compassion, but had not reduced the incidence of pressure ulcers or improved patient compliance with the treatment of pressure ulcers.
- The community matrons held a caseload of patients who had multiple and complex long term conditions. The community matrons could prescribe medication which took some of the pressure off GPs and played a large part in preventing people from being admitted to hospital.
- Community Support Teams, based in GP surgeries, provided support for at risk patients with long-term conditions, enabling them to stay well at home without having to go into hospital. Each team had a social care coordinator and community matron with active links to other health and social care providers, including the voluntary sector. Since January 2014, over 1500 patients had been supported successfully.

Equality and diversity

- All of the patients we spoke with confirmed their needs were being met and were full of praise for the service they received.
- Provision was made for people who did not have English as their first language. Staff could access interpreter services and written information could be provided in other languages or in large print.
- We asked for information to show that the community services were accessing interpreters as needed and monitoring their use. Senior staff told us interpreters were used frequently and their use was recorded in each patient's record but the information was not collated, other than at SpARC. SpARC had used interpreters on average six times a month during 2014, but there was no breakdown of languages used.
- Staff experience of the use of interpreters was mixed. Community teams told us they could access interpreters and that information was available in different languages, but they often relied on members of staff or relatives who spoke the same language as patients. Community therapists told us it could be difficult with rapid response to book an interpreter quickly enough. Referrals did not always include sufficient details regarding interpreter requirements. They told us signers for people with hearing impairment were easier to access.

Meeting the needs of people in vulnerable circumstances

- Although there were no systems in place to flag up when patients had a learning disability, we saw the service responded to the needs of people with complex physical and learning disabilities.
- Community nurses and therapists demonstrated a good knowledge of their patients and particularly those people who were in vulnerable circumstances.

Access to the right care at the right time

Good

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

- The intermediate care service ran a single point of access (SPA) staffed by healthcare professionals. This took referrals from local GPs and other community professionals for frail and older people who would benefit from urgent support. In August to November 2014, more than 90% were seen and assessed by appropriate members of the intermediate care or community teams within 24 hours.
- The district nursing referrals were managed by a call centre staffed by non-clinicians. The call centre staff worked efficiently to respond to calls and faxes swiftly and pass visit requests on to the relevant district nursing team. Call handlers followed a single sheet of guidance for responding to common situations, such as people phoning in having fallen, or with breathing problems. There were no other protocols for triaging or prioritising patients. A call handler said they made the decision "based on common sense" whether a referral was put through to the district nursing team as urgent and needed the district nurse to call that day, or if they could wait until the next day to call. A community nurse told us they were constantly interrupted during the day by responding to calls. District nurses' unplanned workload was variable, but for some teams it could be a significant proportion of the total.
- There was a multi-disciplinary rapid response team that carried out assessments and treatments in people's homes. The falls pathway at SpARC could carry out a rapid assessment within 48 hours. Therapists at SpARC said it was difficult to allocate time to urgent re-assessments due to workload, but a Parkinson's patient could have a phone discussion, or be referred to a community team, as well as be offered an urgent appointment at SpARC. All of these services, helped to ensure patients got the right care at the right time and, where possible, to avoid admission to hospital.
- The intermediate care team supported people at home and prevented hospital admissions. On average, from April to November 2014, they prevented 94 admissions per month.
- The intermediate care team also helped people leave hospital as soon as possible and had supported, on average, 85 patients per month to be discharged from hospital early. The early supported stroke discharge team was a specialist multidisciplinary team, including therapists, psychologists and social workers. The team worked with ward staff at Royal Derby Hospital to help support people to leave hospital as soon as possible and continue their rehabilitation and recovery in the familiar surroundings of their own home.
- The trust was in the process of establishing a 'virtual ward' in the community. A coordinator had just started and there were a handful of patients. This meant that patients could receive intensive health and social care in their own homes, managed by a medical consultant, when previously they would have had to remain in a hospital setting.
- Patients we spoke with told us their experience of discharge and transfer had been good. .

Complaints handling and learning from feedback

- Information for patients about making complaints, raising concerns or giving compliments was displayed in public areas and clinics at London Road Community Hospital. However the information about how to make a complaint directed people to contact the Patient Advice and Liaison Services at the Royal Derby Hospital, rather than providing a local contact. None of the patients we spoke with had experience of raising concerns with the trust.
- Patients receiving care in their own homes told us they did not know how to make a formal complaint, but told us they felt comfortable raising any concerns with their community nurse.
- Community staff understood the complaints process and, if they were unable to resolve the complaint locally, who to refer the complainant to.
- Trust information recorded five complaints about community health services for adults in 2014. Although community health services organisations usually receive fewer complaints than acute services, this was incredibly low. The trust checked this data to ensure it was correct and they confirmed it was. Clinical team leads were responsible for the management of complaints. Informal complaints and verbal comments were dealt with locally. Notes were recorded and fed back at weekly matrons meetings. The records were not reviewed for themes or trends in order to establish wider learning from feedback. The clinical director of the business unit said that complaints monitoring and management were not robust and this was an area for development.

Requires Improvement

Are community health services for adults well-led?

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

Summary

Although there were governance structures in place to monitor and manage risks, and despite the admirable persistence of the lead matron, long standing risks associated with district nursing staffing levels and demands on the service had not been reduced.

Staff felt well supported by their immediate line managers, but there was a lack of clarity about wider community health services management structures and roles, and communication needed to improve. Community staff felt disconnected from the rest of the trust, and services tended to work in silos. Opportunities for sharing learning, engaging with other staff as part of community wide services were not well established.

Most staff we spoke with were passionate about their jobs and were proud of their work. There were a number of successful innovative community programmes taking place both in the trust and with partners in the local health and social care sector.

Service vision and strategy

- The trust had a clear vision statement, to take pride in caring, displayed around London Road Community Hospital. Most staff we spoke with were aware of the trust's vision, values and objectives and showed commitment to caring through their individual and team behaviours.
- All staff we spoke with were enthusiastic and passionate about their roles in ensuring patients received high quality care and treatment .
- The trust's vision and strategic priorities focused on integrated care, and the community clinical strategy, set out in March 2013, was to develop integrated services across acute and community hospitals, specialist therapy and community based therapy, nursing and social care services promoting self-management. Community support teams were established and a therapy review was underway led by the trust's newly appointed chief therapist. Ensuring the required staffing numbers and skills mix in the community health services for adults was proving difficult.
- Community staff at one centre raised concerns that the service level agreement for community services had not been updated for many years. Divisional managers confirmed that the commissioning contract did not reflect current activity, which meant teams were under-resourced

Governance, risk management and quality measurement

- Since the organisational re-structure in April 2014, the quality, risks and performance issues within community health services for adults were monitored through the Division of Integrated Care governance framework.
- Performance and risks were reported as 'dashboard' reports to divisional clinical governance meetings and then on to the trust quality and risk committee as required.
- We saw minutes from four performance and governance meetings in September, October and November 2014. In each one the lead matron for district nursing identified the high risks associated with staff vacancies and excessive workloads. The concerns about staffing numbers and the capacity to meet demand and compliance with mandatory training were escalated to the safe staffing board and the trust quality committee in September 2014. All teams had started the productive community modules aimed at improving efficiency and the quality of patient care. The trust had taken steps to increase capacity in the teams. In January 2014 a decision was taken to over recruit five additional band five nurses to provide cover for maternity leave. in July 2014 the trust agreed to recruit four additional band five nurses for one year. In September 2014, a decision was taken to create an additional 7.6 wte band two support workers. In addition, a 0.6wte band 7 nurse was appointed to provide additional support in governance. A further matron had been interviewed at the time of our inspection and was due to commence in the role in January 2015.

Requires Improvement

Are community health services for adults well-led?

- The call centre handled referrals for the district nursing teams, but covered Derbyshire County teams as well as the trust's teams. The manager was not aware of a formal agreement for this service for other providers.
- The call centre was staffed by non-clinicians. Other than in prescribed emergency situations, they decided if the call needed a visit the same day. They informed the caller the nurse would visit that day, and allocated the visit to the nursing team without knowledge of the team's capacity or priorities. Referrals came in by fax as well as telephone, and these were faxed to the teams. There were no electronic message facilities which would aid communication with teams working remotely.
- The general manager held informal weekly meetings with team leaders across the business unit, to discuss items such as incident reports, complaints, vacancies and recruitment. This meant that the breadth of management expertise could be used to solve problems and develop new ways of working.
- Most community staff we spoke with demonstrated an awareness of governance arrangements. They understood the actions taken to monitor risk and patient safety. This included incident reporting, maintaining a risk register and undertaking audits. Staff we spoke with were generally clear about their roles and accountabilities.

Leadership of this service

- A range of clinical staff told us that communication across the trust to community services was poor. However, community therapists told us communication with the acute hospital was much better and there had been a definite improvement over the last 18 months.
- We spoke with a range of nursing, therapy and support staff based at the London Road Community Hospital. They were not all aware of the local management structures.
- Some therapy staff told us new management roles were created when the service needed more front line staff. This indicated the purpose and potential benefits of the new roles had not been well communicated to front line staff.
- Most staff reported feeling well supported by their line managers. However, some staff in one service told us they didn't know who the managers and line managers were because they kept changing.
- Members of the trust executive team or board did not routinely visit district nursing and other teams delivering care in people's homes. The divisional nursing director and lead matron had carried out 'back to the floor' visits with district nursing teams in October 2014. These had considered safety, organisation, risk management, staff behaviours, information governance, responsiveness, patient involvement and consent. Action points and how these would be followed up were recorded.

Culture within this service

- Staff at all levels reported feeling that community health services for adults were not an integrated part of the trust and were not given as much priority as acute services.
- Community teams thought staff in the acute hospital had a poor understanding of community services and told us about frequent inadequate referrals.
- Community therapists told us about difficulties with parking and transporting equipment to and from their cars, which were essential for their job. They said these sorts of things influenced whether recruited staff accepted posts.
- All staff we spoke with were positive about the contribution they made to patient care and the teams they worked in. One nurse told us "I have the best job in the world." Staff were committed to providing good quality care and told us they were proud of their work. Senior managers spoke highly of their staff and recognised the difficulties and challenges staff faced.
- Staff generally worked well in their teams but some community teams worked in silos, which meant the sharing of best practice and concerns between teams was not as effective as it could be. Therapists at SpARC told us they had no sense of being part of the community hospital or wider community services. Members of the executive team visited the community hospital to attend staff forums, but these were held during patient contact time and they did not have staff capacity to attend them.
- Sickness absence was much higher than the trust average.

Public and staff engagement

- Some staff told us they didn't know who the trust chief executive officer (CEO) was, but others said they had visited London Road Community Hospital (LRCH)and had face-to-face meetings with staff.
- A staff forum called "LRCH Connect" started in October 2013. This was held every two months in the middle of

Requires Improvement

Are community health services for adults well-led?

the day for an hour. It was a forum for all staff working at the community hospital, chaired by the general manager. The format was to have feedback on actions taken since the last meeting, with individual executive members attending to provide updates on their work.

- A staff impressions survey was completed by 66 staff and supported by listening events. This explored staff perceptions of the trust as a place to work and receive care. The results were variable and there was a low response rate from staff in some areas.
- Staff told us that team meetings took place on a monthly basis and locality meetings took place every three months. However, the locality meetings were poorly attended.
- The Pride of Derby awards celebrated the inspirational work of the trust's staff members and the value they added to the trust. We saw evidence of these being awarded throughout community services
- Patient experience was a standing agenda item on business unit governance meetings. Patient surveys were carried out routinely across the service, and the NHS Friends and Family Test was implemented in October 2014. District nursing patients were largely positive but raised concerns with continuity of care and the call centre. The lead matron was putting in place actions in response.

Innovation, improvement and sustainability

- Community health services for adults had a number of initiatives to support early discharge from the acute hospital and to prevent avoidable hospital admissions. These included the early supported stroke discharge team and rapid response team.
- Community services were trialling a virtual ward which was able to provide more integrated, intensive support in the community so that people could receive medically supervised care and treatment in their own homes rather than being admitted to hospital. The new chief therapist had been instrumental in driving this development.
- SpARC was nominated by the US National Parkinson Foundation as one of only two UK Centres of Excellence for outstanding performance in Parkinson's research, care and outreach.
- The trust had an innovative 'training passport app' for smart phones. This was particularly appreciated by staff working in the community and remotely who did not have frequent access to desk-top computers and the trust intranet.
- The trust held integrated care and community services rapid improvement events in May and December 2014. Therapists were enthusiastic about their involvement and the potential for developing new ways of working across the health and social care community in Derby.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider did not take appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced district nursing staff employed for the purposes of carrying on the regulated activity. [Regulation 22]

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not have suitable arrangements in place to ensure that all district nursing staff were able to attend mandatory training and other essential training as required by the needs of the service. [Regulation 23 (1)(a)]

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider did not ensure that electronic patient records could be located promptly by staff visiting patients at home, before providing care and treatment . [Regulation 20 (1)(a) & (2)(a)]