Care And Support Partnership Community Interest Company

1-284354890

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)
1-300312575	Headquarters North Swindon District Centre Thamesdown Drive Swindon Wiltshire SN25 4AN		
1-300312608	Urgent Care Centre Great Western Hospital Marlborough Road Swindon Wiltshire SN3 6BB	<Placeholder text>	<Placeholder text>

This report describes our judgement of the quality of care provided within this core service by Care and Support Partnership Community Interest Company. 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 Care and Support Partnership Community Interest Company and these are brought together to inform our overall judgement of Care and Support Partnership Community Interest Company

Summary of findings

Ratings

Overall rating for the service

Are services safe?	
Are services responsive?	
Are services well-led?	

Summary of findings

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Overall summary

Care and Support Partnership Commnuity Interest Company (trading name SEQOL) provided services for intermediate care, reablement, learning disabilities, dermatology, acute urinary retention, specialist nursing, phlebotomy, rapid response and wheelchair services. However, we carried out a specific focused inspection of only the district nursing and podiatry services provided by Care and Support Partnership Community Interest Company (SEQOL) as a result of concerns we had received about these services. Our findings are reflected in the report.

We did not rate the service following the inspection, as this was a focused inspection concentrating on specific areas of the service.

We inspected the key questions of safe and well led.

We found improvements were required regarding the safety of the service. These included the following:

- The incident reporting categorisation was not clearly defined and not all staff had access to the incident reporting system to record incidents. Reporting procedures, such as defining learning outcomes were not completed and there was a lack of evidence to demonstrate learning was being shared and actions implemented to improve community nursing practice.
- Staff found the incident reporting system difficult to access when they were working out in the community and found the reporting form a challenge to complete.
- There were insufficient community nurses of all levels of skill mix to ensure the care and treatment needs of patients were met. The organisation did not use an acuity tool to determine the correct skill level and mix of staff required to manage with the complexity of patients cared for.
- There were deficits in training and education in the community adult nursing team. Several staff said that the training was not consistently delivered to meet their needs and they were not able to access training as they needed it.
- Despite a lone working policy being available, there was no clear lone working procedure followed by members of the community nursing team. Procedures differed between the teams and did not ensure that staff returned safely from all of their community visits.
- There had been an increase in the number of patients experiencing harm in relation to falls, pressure ulcers and urinary tract infections between the reporting period January to June 2016. The wound improvement project introduced in May 2016 with the support of the tissue viability team, aimed to provide training to address the shortfalls in care provided by with regards to pressure ulcers, some of which were categorised as serious incidents. The community nursing service did not have access to the most appropriate wound dressing products to use on patients and were required to do the best they could with what was available
- Patient care records and risk assessments were not completed fully and were not consistently up-to-date.
- There was no continual monitoring of safeguarding referrals to ensure early identification of trends and themes.

However, we also found that:

- There was an effective system to identify mandatory training needs used by the podiatry department.
- Staff were clear around their role in reporting safeguarding concerns and how they would go about reporting a safeguarding issue.
- The tissue viability team were supporting the community nurses by helping to improve knowledge and skills to identify, categorise and treat pressure ulcers.

We found improvements were required regarding the leadership of the service:

- There was a lack of regular reporting of incidents and complaints at senior management meetings. There were inconsistencies amongst the leaders of the community nursing team in addressing performance issues and ensuring actions following incidents and complaints were embedded into practice
- Community nurses felt supported by their immediate line managers but felt disengaged from senior management.
- Risk to the community nursing service regarding staffing and themes, and trends around pressure ulcers had not been identified as risks and reported on

the clinical risk register. There was very poor compliance with completion of community nurses' yearly appraisals and inconsistent supervision and one to one support.

However, we also found that:

- Staff in the podiatry department felt valued, respected and listened to.
- Leaders in the podiatry department understood the importance of staff engagement to improve the quality of the service provided.
- Team meetings took place regularly to ensure staff were aware of organisational updates and relevant information.
- The culture of the organisation and the staff who worked there was one of a committed workforce who strived to provide a caring and compassionate service.

Summary of findings

Background to the service

The Care and Support Partnership Community Interest Company was established in October 2011 and uses the trading name SEQOL. At the time of the inspection, SEQOL carried out work on behalf of Swindon Clinical Commissioning Group and Swindon Borough Council, providing adult community services to a population of 220,000 in both the urban and more rural areas of Swindon. The community adult nurses were split into four teams, each containing staff with a different skill mix and covered a particular area of Swindon. The community nurse team ran a 24 hour, seven days a week service, offering patients a twilight shift until 10pm and a night service from 10pm until 8am. The community adult nurses that worked the night shift were based at the urgent care centre. The podiatry service was a clinic that ran five days weekly.

This report focuses on the two teams which cover community adult services: community nursing and podiatry. The community nursing team provides care and treatment to patients in the community in their own homes, whilst the podiatry team runs regular clinics in a local health centre.

The local commissioning group had recently completed a tender process for the community services provided by SEQOL in Swindon. As a result of this process the provision of community services will be provided by another organisation from October 2016.

During the inspection, we reviewed 11 patient records and met with 19 members of staff including executive board members, service managers, specialist nurses, community nurses, community matrons, health care assistants, paramedics, podiatrists and administrators.

Our inspection team

Our inspection team was led by:

Nigel Timmins, Care Quality Commission Inspection Manager.

The team included four CQC inspectors and a specialist advisor who has held several positions as a director of nursing services.

Why we carried out this inspection

The inspection was carried out as an unannounced focused inspection, due to information provided by commissioners, stakeholders and patients regarding the community nursing team and podiatry service

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and reviewed reports written by other organisations about the community nursing and podiatry service. We carried out an unannounced visit on 7 and 8 September 2016 and a further unannounced visit on the 26 September 2016. During the visit, we held focus groups with the community nursing staff. We reviewed care and treatment records of 11 patients. We also spoke with a range of staff who worked within the service for example, community nurses, nursing assistants, podiatrists, risk manager, customer services manager, community nursing leads, business managers, the chair and the chief executive of the service.

Summary of findings

What people who use the provider say

We spoke to patients and relatives who were complimentary about the care and professionalism of the staff that provided the community nursing service. We were told staff were respectful, caring and compassionate and were positive and supportive when dealing with stressful situations. One relative told us that the community nurses were "all very nice." Another explained that "I was really worried about everything but everyone's been very kind and that's helped a lot."

Good practice

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Ensure all staff are trained adequately to identify incidents or near misses and to know how to instigate an incident report.
- Ensure policies and procedures are followed for incident reporting and actions from these are monitored to ensure implementation.
- Ensure staff are consistently and regularly provided with good quality feedback from incidents.
- Ensure there are appropriate wound dressings available to meet the needs of the individual patients in the community.
- Ensure all staff are able to access care and treatment plans and risk assessments whilst working in the community whether these are in paper or electronic format.
- Ensure patient care plans are maintained and kept up to date and are an accurate, concise and contempraneous record of care and treatment .
- Ensure risk assessments are completed and reviewed for all patients visited by the community nursing team.
- Ensure patient confidentiality in team meeting minutes is maintained.
- Ensure consistent reporting and monitoring of complaints as recommended by the complaints policy.
- Ensure all staff receive a yearly appraisal in line with policy
- Ensure all staff receive regular supervision in line with policy
- Ensure staff in the community nursing teams are provided with and have timely access to the training and development required to enable them to gain the skills, knowledge and experience to undertake their role.
- Ensure that there is continual monitoring of safeguarding referrals to ensure early identification of any trends of themes.
- To take action to review and assess the staff to patient ratios for community nursing using recognised actiy tools.
- Ensure staff have manageable caseloads which does not require them to exceed planned shifts to complete work on time.Also that they are able to meet the needs of patients and reduce the risk of missed or late calls.

Action the provider COULD take to improve

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

- To ensure that audits are reviewed and actions are taken to address areas of poor compliance. Take action to implement is a formal grading system available to support incident categorisation.
- Take action to review appropriate training and support to administrative staff managing the incident reporting process in the absence of the risk manager.
- Take action to review that all staff are able to log on and access to the electronic records system across a wider geographical area.
- Take action to review ongoing continuity is prioritised for patients where possible, particularly for patients with dementia.
- Implement a robust system to ensure all staff return safely from visits at the end of the day.

Summary of findings

- Review formal daily handovers regarding patient care and treatment.
- The current systems to ensure there are adequate means of security, for example, personal alarms when working alone in areas that have limited mobile phone signal.
- Take action to review a system for full completion of learning outcomes following complaints and incidents.
- Take action to review that leaders are able to lead effectively at different levels to address quality, performance and service delivery issues.

Care And Support Partnership Community Interest Company

Community health services for adults

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We inspected, but did not rate the service for safe. We found that:

- Despite the community nursing staff being patient centred and caring, the care and treatment needs of individual patients were not always met due to the high, complex and demanding caseload for the community nursing staff.
- Insufficient numbers of skilled and experienced staff had impacted upon patient care and had resulted in some missed and delayed visits from the district nursing service.
- The incident reporting procedures and systems for ensuring action were not robust and did not ensure learning was obtained by the organisation. This did not reduce the risk of such incidents reoccurring.
- Not all staff were aware of their responsibilities to report clinical incidents and near misses and clinicians were challenged by the lack of access, not having an individual log on and not being able to access the electronic incident reporting system in the community. Staff also found it difficult to fill out the incident reporting form.
- Ensure patient confidentiality in team meeting minutes is maintained.
- Lone working systems were not consistent and it was not ensured that district nursing staff returned safely from all of their community visits.
- Patients had experienced poor outcomes when receiving care and treatment in that there had been high numbers of pressure ulcers reported, some of which were categorised as serious incidents
- Higher numbers of falls and infections related to the use of urinary catheters had been reported.
- Community nurses did not have access to the most appropriate wound dressing products for use with patients living in their own homes.

Are services safe?

- The patient care, treatment and risk assessment records were not completed fully and were not consistently up to date. Staff had been challenged regarding the use and functionality of the electronic record keeping system.

However, we found that:

- There was an effective system to identify mandatory training needs used by the podiatry department.
- The organisation engaged with other providers to improve safety performance and ensure patients experienced improved outcomes. This included involvement in a local wound improvement project.
- The tissue viability team were working closely with the community nursing team to enhance their knowledge and skills around the identification, categorisation and treatment of pressure ulcers.

Safety performance

- The organisation participated in the patient safety thermometer, which demonstrated the safety performance over time. The safety thermometer was a tool to enable teams to measure harm and the proportion of patients that are harm free during one working day of each month. Data was captured over the course of one day each month and looked at harm from falls, pressure ulcers, venous thromboembolism and catheter associated urine infections. Between January and June 2016, there had been an increasing trend among patients who had experienced one episode of harm and five patients had experienced two episodes of harm in both May and June 2016. The most common harm experienced by patients were pressure ulcers, followed by falls and catheter associated urine infections. Safety performance data regarding pressure damage and falls was reported to the local commissioner of services. Monitoring of additional information to the safety thermometer had taken place regarding the number of patients who had developed pressure ulcers, particularly grade two and three ulcers. This identified a significant number of patients experiencing harm from pressure damage to their skin, however the safety thermometer did not differentiate between patients who acquired pressure ulcers whilst already under the care of SEQOL or those who were admitted with pressure ulcers whose pressure ulcer worsened under SEQOL's care. Data provided showed that the numbers of patients with pressure ulcers increased from 10 to 36 between August 2015 and June 2016. The numbers fluctuated, with a consistent increase in reported damage from 15 in February to 36 in May 2016. The organisation felt that the rise in pressure ulcers had been partly due to a training programme provided to community nursing staff in February 2016. The training had raised awareness of skin integrity and had led to increased reporting of pressure ulcers across the whole organisation.
- The organisation had appointed a tissue viability lead nurse who had been in post for eight weeks at the time of our inspection. Prior to this appointment, support had been provided to staff from an external consultant. We met with the tissue viability nurse and were provided with information about how the tissue viability team supported staff across the organisation with complex wound management programmes. The risks around pressure ulcer management in the community were addressed on the community nurse quality improvement plan and we saw the action plan to manage the risks around pressure ulcers in the community. Each action had been assigned to a particular staff member to carry out and identified how the actions would be monitored. Despite this being acknowledged as a risk. Pressure ulcer management was not on the strategic risk register.
- The tissue viability nurse had worked with community nurses by providing training regarding the assessment and management of pressure ulcers. Following the training, the numbers of pressure ulcers reported had increased. The organisation viewed this as a positive development, in that staff were confident in recognising, assessing, grading and reporting any skin pressure damage experienced by patients.
- A local initiative known as the Swindon wound improvement programme (SWIPE) had been launched in May 2016 and SEQOL were part of a number of organisations who were participating in this. The project was commissioner led and aimed to review the management of wounds across the Swindon Health Economy and was in conjunction with the West of England Health Academic Health Science Network. The preliminary stages consisted of an observational audit of 98 wound dressing changes and wound care episodes, an online knowledge and skills survey for nursing staff and data was also collected from a patient completed quality of life survey. From this,

recommendations were made to enable services to improve wound care management. Recommendations included further education and training, particularly for the community nursing team, better documentation to monitor the progress of wounds by the use of photographs and a better-defined formulary, range of products and education around this.

- The SWIPE (Swindon wound improvement programme) project had identified subjectivity in the categorisation of pressure ulcers resulting in the incorrect assessment and grading of pressure ulcers and a lack of education and training regarding categorisation of pressure ulcers. The project had specifically highlighted the community nursing team as a priority for training in this area. In light of this, a quiz had been developed to use as a learning tool for staff using images to enable staff to increase their skills in identifying graded pressure ulcers.
- There had been an increase in the number of patients who experienced harm following a fall. Patients who were provided with care and treatment by the community nursing team who had fallen and experienced harm from January 2016 to July 2016, rose from one in January to 15 in May 2016. An audit had been completed in August 2016 which had aimed to analyse the data around falls. The audit did not offer any conclusions about the increase in falls during this time period and recommended a further investigation. There was however, a multifactorial falls assessment built into the community nurse assessment process in the electronic record system, which was devised by the therapy team and was compliant with National Institute for Clinical Excellence in Health guidelines.
- A questionnaire had been produced to provide further insight into why patients had fallen in the community in August 2016, but only two of these had been completed. From the two that had been completed, it was apparent that no falls risk assessment had been undertaken and no falls prevention plan had been actioned for the two patients. However, the falls programme, including maintaining the register, carrying out audits and implementing and monitoring falls action plans were managed on an organisation wide basis by falls co-ordinator who was part of the intermediate care team.
- There had been an increase in numbers of patients who had experienced harm from catheter associated urinary tract infections. Between January and June 2016, the numbers of patients who had experienced harm had increased from two patients in February and May 2016, to seven in June 2016. However, the safety thermometer did not differentiate between patients who acquired catheter associated urine infections whilst under the care of SEQOL and those admitted to the service with a catheter associated urine infection. It also does not identify the numbers of patients with catheters on the caseload in the months reported. There was no evidence of further work carried out to determine the cause for this increase.

Incident reporting, learning and improvement

- Most staff understood their responsibilities to raise concerns and to report incidents and near misses. Most staff were open, transparent and honest about reporting incidents; however, we saw evidence of incidents and near misses written in a book that had not been reported as incidents. Also, some staff had not completed training around incident reporting. Staff were required to report incidents and serious incidents regarding events that adversely affected patient care and outcomes for patients and staff.
- The service's policy set out the timescales required for incident identification and the processes for reporting, investigating and managing incidents. The policy described the investigation process and the roles and responsibilities of staff involved in the process.
- Incidents were reported using an electronic system. Once reported, incidents were reviewed by managers and where necessary investigated.
- There was no formal grading system to categorise incidents. The incident reporting policy stated that all incidents had to be graded according to the severity of harm to identify serious incidents. The only information available was regarding the definition of a serious incident and the policy was unclear on how the organisation required other incidents to be graded. It was the role of the risk manager to categorise incidents but there had been no training provided to community nursing staff about the incident grading system. We were told that senior clinicians would support the risk manager to grade an incident if required.
- The incident reporting system and processes were managed solely by the risk manager. In the risk manager's absence, incident management would be passed to the administration team. They would be required to set up the appropriate documentation, report serious incidents on the serious incident

reporting system and categorise incidents with the support of senior clinicians. They had no formal training around the management of the incident reporting process, just basic typed instructions provided by the risk manager. Senior management felt that the administration staff were competent to take on this role in the absence of the risk manager.

- A comprehensive spreadsheet of all incidents reported was in place, which tracked the progress against deadlines for completion. We saw evidence that an investigation and 72 hour report was initiated and completed for serious incidents and an investigation manager selected.
- Risk management awareness and reporting training formed part of the induction programme of which 83% of staff had completed at the time of our inspection. This meant that not all staff were able to identify when an incident had occurred, assess the severity or know how to instigate a report. However, at the time of our inspection, 50% of permanent staff, mainly band five community nurses and band three and four nursing assistants, had not completed the training to access and use the incident reporting system. Temporary staff did not have access to the electronic reporting system and relied on managers or colleagues to report an incident. Staff were unclear about their accountability for such incidents.
- Despite the initial training on induction, there were 16 common, repeated errors made by staff when completing incident reporting forms. These included the terminology used to identify people involved, the use of identifiable information and classification of the incident. The risk manager would contact each individual directly if an error was picked up, however, if a member of staff repeatedly made the same errors, this would then be reported to the individual's team manager to deal with.
- Some staff said they were not confident in using the electronic reporting system and as a result, it took them around 20 minutes to complete a report.
- We observed written evidence collected by community nursing staff which identified incidents they had encountered during shifts. These included missed medication, missed visits and the lack of specialist equipment available. We were told that these incidents had not been recorded on the electronic reporting system due to the length of time it took to record the incident and that not all staff had access to the reporting system. During the inspection, a near miss was observed whereby a visit to administer insulin was missed. This appeared to be due to a failing of the system used to plan and deliver care. Despite the concern immediately being addressed, staff were unaware that this constituted an incident that should be reported.
- There was a framework for the management of serious incidents in line with the expectations of the National Patient Safety Agency. All serious incidents were investigated using root cause analysis and the timescale for completion of investigations was dependent on the grade of the serious incident
- There were 31 serious incidents reported during the period from December 2015 to March 2016 of which 67% were grade three and four pressure ulcers. This number decreased to 11 during the period from April to July 2016 of which 91% related to pressure ulcers.
- Despite these improvements, some recurring issues remained. We saw, from two of the root cause analyses (RCA) for June 2016 which identified that lessons from previous RCAs were not effectively resolved and incidents concerning pressure ulcers continued. The timely ordering of equipment and dressings also remained a regular root cause.
- Several key issues repeatedly arose within the reported serious incidents. Communication errors (both internal and external) had led to breakdowns in care planning, liaisons with family and missed visits. Gaps in information had led to inconsistent care being administered due to protocols not being followed. Missed visits and incorrect wound care were the two main reasons behind serious incidents. Further investigation of these incidents had identified that the causes of the serious incidents were due to communication errors and a lack of quality documentation regarding care and treatment. A review of serious incidents had taken place between April and July 2016.The outcome suggested there were reasons to explain the reduction in incidents. The report identified that the new electronic record system had improved record-keeping and internal communications and had streamlined record-keeping making it more likely that care plans were adhered to. Between April and July 2016, three incidents reported problems with the new system as a root cause. In all of these, the problems arose from staff either using the system incorrectly or

not providing sufficient documentation. Team meetings had also been commenced in March 2016 with an agenda item being the review of all pressure ulcers by the team and at the matron's team meetings. Managers were confident the meetings had directly contributed to the decrease of serious incidents. Of the eleven incidents reported, only two had mentioned a lack of senior management involvement as a lesson to be learned. This was not on the strategic risk register.

- Between April 2016 and June 2016, there had been 79 clinical incidents and serious incidents reported by the community nursing team. A common theme emerging was pressure ulcer reporting. Grade two pressures ulcers were the most common and contributed to 44 of the incidents reported between this time period. Other clinical incidents included grade one and three pressure ulcers, implementation of care and ongoing monitoring or reviewing treatments and procedures, delays in patient care, medication errors and infrastructure failures, for example, unreliability of the computer systems.
- Staff said they were not consistently provided with feedback on incidents they reported. There were inconsistencies between the quality of the feedback provided around incidents at the community nurse meetings. Feedback from incidents was an item on the weekly agenda for the nursing team meetings. We observed 11 sets of minutes from community nurses weekly team meetings and matron's' meetings. Out of the 11 viewed, three of the meetings had addressed feedback from incidents; however, these were of limited quality and depth. Other teams had used this section to discuss patients with complex needs, whilst there was no mention of incidents at the matrons' meetings.
- Staff reported that they did not receive individual feedback from reporting incidents. Some of the staff said they did not feel all incidents were acted upon. Staff were also concerned that not all incidents were reported.
- There was a lack of compliance with completion of learning outcomes on the incident reporting system. Of the five closed incident reports that we looked at, only two had completed actions and learning outcomes following the incident. However, only one of these completed contained an in depth breakdown of the learning outcomes following the incident. The other completed form did not demonstrate any learning outcomes gained from the incident.
- There was a lack of communication and feedback between the senior management team following a recent audit of incidents. The audit had been carried out by the director of finance. When this was discussed with the associate director for quality and professional lead and the community nurse professional lead, they were unaware of the outcome of the audit or any areas of concern.
- The podiatry department completed a corrective and preventative log following each reported incident. We saw examples where immediate measures had been taken following the incident and further preventative measures to avoid the incident occurring again. For example, confusion around patient appointments led to appointment letters being sent out to patients to remind them of their appointment details. We saw evidence of comprehensive learning systems and action logs held by the podiatry service to ensure a record of incidents and learning that had come from these incidents.
- A quarterly report was developed regarding the serious incidents which occurred and was presented to the service's board meeting. We observed minutes from the July 2016 board meeting where serious incidents were discussed and a decision taken for a summary of action and learning brought to the board. This was assigned to a member of staff to action. However, we reviewed board minutes from August 2016 where we saw no evidence of updates on the progress of this action. We observed the action logs from the board which contained no record of this action. However, a new standard operating procedure had been introduced to ensure an appropriate response from the community adult nursing team in relation to high risk pressure ulcers in the community. The new operating procedure required a referral to be made to the tissue viability team for reassessment within 72 hours to ensure the patient received the most approprioate care from the team most specialised to provide this.

Duty of Candour

- All staff demonstrated an understanding of duty of candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation relates to openness and transparency and requires providers of health and social care services

to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, however not all staff were reporting all incidents and near misses.

- We saw there was information about the duty of candour for staff within the incident reporting policy and within the electronic incident reporting system. There was an appendix to the policy which described the process for managers to follow during the process of managing incidents.
- We saw evidence that on two occasions, where appropriate, the duty of candour processes had been applied, with serious incident reports having a dedicated section for recording the actions taken.

Safeguarding

- There were policies, systems and processes in place for staff to follow regarding the safeguarding and protection of vulnerable people. The policy described the roles and responsibilities for staff in reporting concerns about patients. The community nursing team only treated adults and did not treat children.
- Staff we spoke with were knowledgeable about the safeguarding policy and processes and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of abuse.
- The organisation had a nominated safeguarding lead. The responsibilities for safeguarding had become an additional role for this member of staff. Due to workload pressures, we were told that while the safeguarding lead reviewed all safeguarding referrals made through the organisation's electronic reporting system, no internal monitoring had been carried out to identify any patterns or themes. However, patterns or themes relating to safeguarding were monitored on a system wide basis by the Local Authority Adult Safeguarding Team. The safeguarding lead also had responsibility for reviewing all incidents reported to ensure they did not require additional safeguarding processes to be applied.
- We were provided with examples of when staff had made safeguarding referrals to the local safeguarding authority. For example, on one occasion, an inappropriate discharge from hospital had caused health risks for the patient. On another occasion, staff had concerns regarding the actions of family members which they had subsequently made a safeguarding referral about.
- Safeguarding was reported at the quality forum and the board received assurance for safeguarding through reports on training and incidents.
- Not all of the community nursing staff were compliant with safeguarding adults and children training. Of the community adult nursing team, 79% of nurses had completed safeguarding adults and children training. The data provided by the organisation represented the whole of the community nursing workforce and also included staff who would not be expected to complete the training due to being on maternity leave or on long term sick. We were not provided with data that represented the number of staff who were included under these categories and were therefore unable to see how this impacted on the overall compliance with safeguarding training.

Medicines

- This section was not included as part of the focused inspection.

Environment and equipment

- Facilities and premises within the podiatry clinic at Swindon Health Centre were designed in a way that kept people safe. However, the clinic was based in a shared building in need of modernisation where space was limited. There were plans for a new build centre to be completed in 2017.
- Consulting and treatment rooms used by the podiatry service contained facilities and equipment appropriate to the specialty. Systems were in place to ensure the safe use and maintenance of equipment.
- The community nurses had access to equipment to enable them to provide care and treatment for patients in their own homes. There had been an equipment list developed in line national recommended guidance for skin care for individual tissue viability needs and could be ordered by the community nurses from the organisation's equipment store. All community nurses were issued with a code which provided them with the authority to order equipment. Teams had access to equipment either by a routine pathway, taking three working days to arrive, or urgently, which staff could access on the same day. There was also an option to access more specialist items of equipment with the support of the tissue viability team for more complex patients.

Are services safe?

- Staff told us that they were trained in the use of specific equipment where necessary and that the equipment was serviced and maintained in line with manufacturer's instructions. We did not review records to evidence the servicing and maintenance of equipment during this inspection.
- A wound dressing list was in place which enabled staff to stock up with dressings and equipment prior to attending patients in their own home. At the time of our inspection, staff told us that the dressings available did not always meet the needs of patients. For example, we observed the care and treatment for one patient and observed that the dressings available were not large enough to cover the wound. Staff had to use several smaller dressings and experienced difficulties in securing the number of smaller dressings used. Wound dressing equipment was reviewed with commissioners to ensure it was cost effective and evidence based.
- There was ongoing work around developing the formulary for wound dressings. A working group was in place to look at improving the formulary to ensure the most effective equipment was available for use and waste was reduced

Quality of records

- Processes were not always followed for the management of health records. This policy identified the standards expected of all staff who were required to keep accurate records and protect the confidentiality of service users' personal identifiable information.
- There was an electronic system in operation which was accessible via laptops provided to the staff, which provided a record of the care and treatment required by and provided for patients. This was used by the community nursing and podiatry teams. The services also used paper records which remained in the patients homes.
- The system could be accessed from office bases or remotely through the use of mobile computers when in the community. However, network connectivity issues in some areas meant staff were unable to access the electronic records. When this occurred, they made hand-written notes and updated the electronic record at the earliest opportunity. The inability to access the patient's electronic records put patients at risk due to staff not being aware of the most up-to-date care and treatment plans and risk assessments for their patients. Staff said that they did not always report issues or system failures as they would be required to attend the office to resolve the issue with the IT helpdesk and they did not have time to do this.
- Staff reported that they had received training on the electronic system and had been provided with log-on details. However, two members of staff reported their log-on had never worked and administrative staff entered patient details on to the electronic system for them. This took place once they returned to the office and advised the administrators of the information. These staff had not been able to access the patient care records on their laptops whilst working in the community however; this risk had not been identified and added to the risk register.
- Agency staff were provided with a printed care plan and used these to record any care and treatment hat was provided. These were then returned to the office for an administrator to upload and update the electronic record system.
- Staff said it was difficult to complete comprehensive records due to time constraints and often updated records in their own time at home.
- Paper records were available in patient homes and the community nurses completed these to provide information on the care and treatment provided and the outcome of the visit.
- There were inconsistencies in the quality of records. We looked at a combination of eleven electronic records and care plans. Information was clear and concise in one, but the others were poorly populated and not all information had been transferred to the electronic system. This could mean staff would not have the most up to date information when seeing a patient.
- Patients were discussed at the community nursing team meetings. The minutes of the meetings contained the names of patients and discussions about their care and current status. This process did not support the confidentiality of the patients using the service and conflicted with the Data Protection Act of 1998.

Cleanliness, infection control and hygiene

- Systems were in place to prevent and protect patients from healthcare associated infection. The medical director was the director of infection prevention and

control within the organisation. The lead nurse reported to the quality and professional lead within the organisation to ensure that any issues with infection control were escalated appropriately.

- Each team of community nurses had a named link nurse to provide additional support with any infection control issues.
- Infection control training had been completed by 70% of the community nursing staff.
- There was an infection control annual plan which contained an audit programme and was monitored through the quality forum. Audits were undertaken by the team leaders for services and results monitored and fed back via the infection control team administration assistant. We observed the results from the 2015/2016 infection, prevention and control audit; however there was no action plan or any record of how improvements were going to be made and how this was to be monitored to improve compliance with the audit.
- The podiatry clinic we visited was based on the ground floor of the Swindon Health Centre. It was maintained, organised and clean despite the challenges of an old building that lacked space. We observed staff washed their hands regularly and used anti-bacterial gel appropriately. Hand sanitisers were available and clearly visible at the entrance to the clinic. Equipment such as aprons and gloves, were used to prevent cros contamination and the spread of infection.
- Staff followed infection, prevention and control procedures at the podiatry clinic. We observed staff cleaning used equipment and the surrounding environment between appointments.
- We observed community nurses providing care and treatment to patients in their own homes. In each home with the exception of one, the nurses had access to gloves and aprons to promote the spread of infection. We observed that one visit took place in a very warm environment and staff did not wear plastic aprons. They mitigated against cross infection by ensuring the episode of care was the last visit of the day.
- Staff did not have access to sterile gloves apart from those provided in dressing packs. This meant that if a nurse required more than one pair of gloves during a dressing change, more dressing packs had to be opened unnecessarily. During one dressing change, we saw four dressing packs opened to provide sufficient sterile gloves to enable the nurse to carry out the dressing using a recommended aseptic non touch technique procedure.

Mandatory training

- There was a clear database to identify when mandatory training for members of staff in the podiatry department required updating. Information was stored electronically on a live database for each individual and identified in green when training was in date. The system would change to orange 60 days before training became out of date to enable staff to book on their mandatory update. A member of the administration team would identify and inform staff when an update was required. This was also a regular topic at one to one sessions. The database was set up following confusion amongst staff as to how often specific mandatory training had to be refreshed. The podiatry team were all up-to-date with mandatory training.
- A programme of mandatory training was provided for staff which included safeguarding awareness (adults and children), fire awareness, dementia supporters (awareness), infection control, health and safety awareness, conflict resolution/personal safety/lone worker, risk management awareness and reporting and equality and diversity. Role specific training included anaphylaxis, catheter care, falls, medical devices, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), pressure ulcers, resuscitation and manual handling.
- Mandatory training was undertaken either during face to face sessions, e-learning or via a self-directed learning package.
- There were deficits in training and education in the adult community nursing team. Several staff said that training was not consistently delivered to meet their needs and that they were not able to access training as they needed it. However, the senior management team reported that training was advertised well in advance of the sessions. Staff reported they were not able to access additional training unless they were up to date with their mandatory training and all applications had to demonstrate the training requested benefitted the community nursing team. No requests had been refused in the past five years. Data provided on overall compliance with mandatory training showed that staff were not up-to-date with their skills and knowledge to

enable them to care for patients appropriately. As of June 2016, 83% of community nurses had completed risk management awareness and reporting training, whilst only 50% had completed training to use the incident reporting system and 57% had completed conflict resolution, personal safety and lone worker training.

- Specialist district nurse training had not been available in Swindon for some years. The organisation supported some training pertinent to the role of the district nurse, but not an overall district nurse training programme. Funding for nurses to undertake full district nurse training was not available nationally or locally.

Assessing and responding to patient risk

- There were inconsistencies in the assessment and response to risk. Risk assessments were not consistently completed for patients visited by the community nursing service. It was not always clear to staff of the individual risks associated with patients. There were not always paper risk assessments in the home of the patient and staff did not always have access to the organisation's electronic record system. This meant that we were not assured that robust assessments of the risks to the safety and quality of patient's care and treatment was carried out.
- Agency staff were provided with a printed care plan from the electronic system which identified the care and treatment they were expected to provide. They were not provided with a copy of any relevant risk assessments. This meant that there was not appropriate guidance in place for these staff to follow to manage the risks to safe care and treatment.
- We asked to review the risk assessment and care plans for one patient who staff had expressed concerns regarding risks posed by the patient and their environment. There was not a clearly identifiable section of the electronic patient record system for the risk assessment to be stored and two senior members of staff had difficulty in locating the risk assessment. A member of the administration team located the risk assessment and we saw that it was stored within the letters relating to the patient. This did not ensure that staff would have been able to locate or access the assessments and subsequently take appropriate action to reduce the identified risks.
- Directions on the risk assessment paperwork were not followed by staff for one patient. The member of staff took an alternative action but this was not recorded on the risk assessment or care plan. This meant that other staff visiting the patient in the future would not be aware of the actions taken or any potential adverse outcomes following these actions.
- There was a new standard operating procedure to enable community nursing staff to respond appropriately to patients with high risk pressure ulcers in the community. Patients with grade three and four pressure ulcers would be referred to the team for reassessment within 72 hours. A referral was made via email to the tissue viability team and administration support, and the patient was added to the team's caseload. The new procedure ensured the most effective use of the team's specialist skills and knowledge.
- The tissue viability team were aiming to improve the knowledge and skills of the community nursing team to enable them to better respond to patients at risk from a new or further deterioration of pressure ulcers in the community. The team had provided training and education to the community nursing team through the use of joint visits, to support with complex patients. The aim of this was to ensure that the tissue viability service remained a specialist service. The community nurses also had the opportunity to attend tissue viability clinics to further develop knowledge and skills.
- The tissue viability service planned to analyse visits they were undertaking relating to grade three and four pressure ulcers to identify specific themes and trends in specific community teams in order to respond to any risks around care and treatment to patients. This review was intended to analyse themes and trends regarding the development of grade three and four pressure ulcers. This would then enable to tissue viability team to identify areas of risk and what actions were required to reduce risks to patients.
- Staff provided us with examples of when patients refused or changed the recommended care or treatment plan. Where patients had the mental capacity to make their own decisions and chose to refuse or change treatment, the staff explained the risks fully. These discussions were recorded on a defensible decision form and patients were asked to sign the form to show they agreed with the information. One patient

refused treatment but would not engage with the process of the decision making and would not sign the form. Two nurses signed the form to witness the conversation which had taken place.

- Community adult nursing staff did not have daily face to face patient handover meetings. Staff told us these used to take place either in the mornings or at lunchtime but had stopped mainly due to pressures of the workload. Other teams had found that when they met in the office there were often interruptions from other staff which meant the meetings took more time than was available. Staff now communicated by text message, telephone or email to hand over any visit information or ensure colleagues were aware of any patients who were poorly or needed additional visits.
- There was no formal handover process for the community nurses working on nights. The nurses working on the night shift said they would often call the co-ordinator working on the twilight shift to get a handover prior to starting their shift. There was the option of using the task function on the electronic record system, however, due to demanding caseloads, a reduced workforce and lack of time we were told that this option was rarely completed or read by members of to the community adult nursing day team due to workload pressures. Nurses said they frequently used text message or telephone to hand over during the day, however, the night nurses reported that they were not part of this process. The community night nurses felt disconnected from the day team. Night staff also told us of the challenges of handing over to the day team. Due to the lack of compatibility of timing between the night shift ending and the day shift starting, it was often very challenging to speak to a nurse from the day team to handover patients from the night shift. Nurses on the night sifts would also use the task function on the record system, however they could not guarantee that this would be seen by the nurses on the day shift due to caseload pressures and lack of time.
- During our inspection, we visited the homes of five patients and found that their care and risk assessment documentation was not up to date. We saw incomplete records of equipment that was in use in patients' homes. Risk assessments did not reflect all equipment that was in use.
- Due to the limited access to the electronic records system when in the community, nurses were not always aware of the recommended care and treatment for all patients. We were told that the tissue viability specialist nurse had visited one patient and recommended a change in the patient's care and treatment. Their records were made on the electronic system. The community nurse attending the patient had not been able to access the electronic records due to a connectivity failure so had been required to telephone the office to be provided with the relevant information. They had recorded a list of dressings and creams to use in the paper records in the patient's home in a list format. This did not equate to a care plan which would inform and guide staff on the action to take when providing wound care for this patient. The tissue viability specialist nurse advised us that their role was one of advice and support to the community staff. They recorded their findings and advice within the electronic patient records, but the subsequent updating of the patient's care and treatment plan was the responsibility of the community nurses.
- Referrals to the community nursing service were through a single point of access triage service. Teams were responsible for a number of GP surgeries and all patients who required a service were allocated to the team for their GP. We spent time with three community nursing sisters (senior band 6 registered nurses) during our inspection. One sister had responsibility for 11 GP surgeries and we saw there had been 55 calls by 11.30am, of which six were new referrals. The nurse did not have capacity to see all six new patients so planned to ring the patients, review the referrals and then prioritise which staff were to visit the patients. This was impacting on the nurse's ability to maintain her caseload and provide one to one supervision sessions and support for the team. Staff told us this was a daily occurrence.
- The West of England academic health and patient safety network had carried out joint work with SEQOL regarding recognising the deteriorating patient with sepsis. Monitoring of the organisations early warning system had taken place and the findings from this were due to take place later in September 2016.

Staffing levels and caseload

- There were inadequate community nurse staffing levels to safely meet the needs of patients. Despite the community nursing staff being patient centred and caring, the care and treatment needs of individual patients were not always met due to the high, complex

and demanding caseload for the community nursing staff. We were given examples of patients calling the service several times to find out when a nurse was due to visit and at what time with the outcome was that a visit did not take place. Staff told us they were visiting between 13 and 20 patients each day. They found this challenging and were frequently working over their agreed contracted hours to ensure that patients were seen and work was completed. We saw evidence which showed staff exceeded their planned shifts and worked late into the evenings at home updating patient records when they should have been off duty. Staff told us they were frequently telephoned on their day off regarding work issues.

- Community nurses worked from 8am to 10pm following a shift system. Night cover was available from 10pm to 8.30am.
- We spoke with a range of staff from healthcare assistants to community matrons, who had expressed concerns regarding the levels of staff within the community nursing service and the size of the caseloads managed by the teams.
- Staff commented that the numbers of patient referrals had increased and that the patient's acuity (their assessed level of dependency and care needs) was greater than in previous years. The organisation had carried out some primary care NHS benchmarking in community settings and found that last year, the organisation was in the top 10 nationally for caring for and treating patients with complex needs.
- We spent time with community nurses observing them carry out their visits to patients. We noted that during one visit one nurse had four telephone calls and her colleague had two. In another visit, the community nurses telephone rang three times. We commented on this following the visits and were told 'it does not stop'. The calls were regarding patient visit requests from the single point of access team and requests for advice and support from other staff. Depending upon the situation, at times, visits would take longer due to nurses having to take the call, whilst on other occasions; calls were not answered until the nurse had finished their visit. We saw from the complaints outcome report, that complaints had been made from patients about staff taking calls whilst delivering care in patients' homes.
- Data provided by the trust showed that the community nurses consistently carried out a higher number of contacts with patients than the target agreed with the contract with the commissioners. The target patient contacts for the community nursing team for 2015/2016 was 90,112 contacts with 81,680 being provided by community nurses for all skill levels and 8,432 contacts being provided by matrons. However, the performance by the end of March 2016 had exceeded the commissioners' targets for both community nurses and matrons and was in excess of 102,508 patient contacts. SEQOL had raised the issue of growing demand on services with commissioners at monthly contract meetings.
- We were told the organisation was not using an acuity tool at the time of our inspection therefore this did not enable them to measure and assess staffing levels appropriately. The reason given for this was that the commissioners had agreed to purchase the system to help the service plan appropriate staffing according to the level of demand and the complexity of the patients' needs that were being referred to the service. At the time of our inspection, this computer software had not been received.
- The organisation relied heavily upon the use of bank and agency staff to cover for sickness, absence or vacancies. Bank and agency staff had covered 231 shifts between July 2015 and June 2016. The service had 6.64% whole time equivalent nursing staff vacancies which equated to 10% of the community adult workforce. Staff felt the current position was fragile and although there was high resilience amongst the team they felt they were "left holding the fort."
- Across the community nursing teams we were told and also saw data which showed there were 10% nursing vacancies which equated to 6.45 whole time equivalent (WTE) staff members. This was within a staffing establishment of 69 WTE members of staff.
- Sickness rates for staff for the preceding 12 months showed the district nursing team having a sickness rate at nearly 3.3% and the podiatry team having 0.5%.
- Managers were aware of the risks the recruitment difficulties presented to capacity and continuity of care. There had been a 13.04% turnover of staff from the community adult nursing team. This equated to there being nine substantive staff leavers over the past 12 months between July 2015 and June 2016. This had been monitored via performance reports and action plans had been implemented to drive recruitment. The

organisation had experienced difficulty in recruiting staff which they considered to be partly due to competition from other health employers in the area. Staff turnover had been escalated to the strategic risk register.

- There was ongoing recruitment with 105 hours for band five staff in process. There were a number of applicants that were at the stage of being shortlisted for positions. Recruitment of new nurses to the team had been positive, with many student nurses who had experienced placements at SEQOL during their training wanting to work for the organisation permanently. However, this had led to problems regarding the skill and experience of newly qualified nurses working alone in the community.
- The diabetes specialist nurse post of 37.5 hours was vacant but interviews had been postponed until further notice.
- There was a vacancy for a 30 hour phlebotomist for which an interview had been planned the week following our inspection.
- The organisation was planning the advertising for a community matron and a community intermediate care practitioner as these positions were vacant.
- Staff often worked overtime to cover shifts. We observed one member of staff attended the staff meeting on their day off. The community nursing service also used local agencies to assist the community teams in filling their duty rota. The night nursing team of four nurses worked together to cover any sickness or annual leave amongst themselves. We spoke with a member of the night team who had recently had to cancel a shift due to sickness. The nurse informed the urgent care centre co-ordinator and then the other night nurses by text message where a colleague volunteered to cover the shift. Nurses said they could not remember a time in the last year when a shift had not been covered. We observed paper copies of the night nursing rotas for the last six months which demonstrated cover and shift swapping amongst the night nurse team, where all shifts appeared to have been filled. If this instance occurred, calls would be passed to the GP to ensure that patients received the treatment they required.
- Paramedics had been recruited to work within the community to address the shortfall of community nurses Following additional training, they were able to respond to urgent requests to provide care and treatment to patients living at home. This included caring for intravenous infusions and blocked urinary catheters and the application of wound dressings. This enabled community nurses to undertake routine and holistic, care as well as assessing and care planning for new patients.
- Due to the gaps in the duty rota, it had been difficult to ensure continuity of staff for patients. For example, one patient living with dementia had had 11 members of staff visiting over a period of 40 days. Senior staff were trying to reduce the numbers of staff visiting each patient to provide continuity of care to individuals. The work plan had started with patients with complex care needs.
- One community nursing team visited a patient where concerns had been raised about risk factors regarding their behaviour and actions towards staff. A rota had been put into place in that only two members of the staff team visited this patient.
- The podiatry department had seen high rates of staff turnover within the last 12 months. Podiatry had a small deficit of 0.54 WTE members of staff with 9.0 WTE staff in post. The department had nine substantive staff members with seven of them having left the service in the last year. This accounted for a 77.8% turnover of staff in the department. There was at the time of inspection a 50.1% vacancy rate within the department. There were vacancies for a band 5 clinician and a diabetic specialist podiatrist. The shortfall had been managed by the use of locum podiatrists, some of whom had accepted substantive posts. Within the last year, 133 shifts had been filled by locum staffing. Workforce information was closely monitored and captured in quarterly reports.
- With the use of locum staff came a new trend in incident reporting, for example sharps incidents and issues with sterilisation packs not being returned correctly. This led to the provision of a day's induction for locum staff who were trained and educated in the day to day running of the clinics. This included spending the day with a competent member of staff from the team.
- The service did not have a robust system to respond to missed visits. There had been complaints received regarding missed or delayed visits. Staff gave us examples of when patients had experienced missed visits which had resulted in poor outcomes for them. For example, one patient had telephoned repeatedly to request a visit to redress their wound but they had not received a visit, another patient had experienced missed visits for their insulin injection.

Are services safe?

- During our inspection, we visited the homes of five patients and found that their care and risk assessment documentation was not up-to-date. We saw incomplete records regarding equipment that was in use in patient's homes. Risk assessments did not reflect all equipment that was in use.

Managing anticipated risks

- Risk was not consistently recognised and managed. There was a lone working policy in place and staff we spoke with were aware of this, however, each team had a different way of managing lone working.
- There was a buddy system in place for joint working if staff were making potentially difficult visits. However, staff were not always aware of potential difficulties on visits. This was due to the lack of the lack of completed risk assessments and the inability to access the electronic record system whilst out in the community. At times felt they were "going in blind" and felt uncomfortable and vulnerable in these situations.
- It was not clear whether a formal system was in place to ensure that all staff returned from their visits safely. Staff did not report into a central point and arrangements varied between teams. Systems and procedures at a local level had been discussed at neighbourhood meetings to ensure the safety of staff working alone in the community. Staff in some teams sent a text message to their senior colleague when they had finished their visits and discussions were ongoing about staff using a code word to alert colleagues if they found themselves in dangerous situations. There were no formal patient handovers during the day or at the end of the evening shift prior to the night community nurses starting work. However, staff we spoke with said they were constantly in touch with their team colleagues during the day using their mobile telephones and were confident they would know if anyone was in danger.
- We spoke with community nursing staff who worked alone at night. They told us there used to be a bleep system in place for the night staff but now all calls came through the telephone controller directly to their mobile telephone. The controller was aware of all the calls and visits the night nurse carried out and the addresses of all patients visited. The nurses we spoke with were confident that the controller would raise the alarm if they did not return from the arranged visits in a reasonable time. Staff said they had their own methods of ensuring their safety when out alone during a night shift, for example, one nurse telephoned the patient when she was outside the property and continued the conversation until she entered the property. The night staff had not been provided with personal alarms and there was no code word in use that nurses could use to alert the person on the telephone that they were in danger.
- Personal alarms which were linked to a local security firm had been ordered but were not in place at the time of our visit. Staff were concerned about the poor mobile network signal in some areas and the impact this had if they were working alone and found themselves in a difficult situation requiring support. They felt vulnerable and "left to their own devices."
- Staff were not completing risk assessments despite being aware of patients or family members that posed a risk to their safety. In one example there was no risk assessment completed despite a documented patient record which identified risks posed by family members at previous visits. There was no risk assessment in place to advice staff on the action to take to reduce the risk to themselves. Staff told us about another patient who presented with abusive and, at times, challenging behaviour towards the staff. There was no completed risk assessment on the electronic system. Staff told us there would be a paper risk assessment recorded in the home. We did not visit this patient so were unable to ascertain if this was in place. Staff added that the patient often mislaid or threw away paperwork so they were not confident it would be accessible at their visit.
- The electronic system in use highlighted any security risk or risk from individual patients on the front page of the patient electronic record. Three members of staff we spoke with informed us that when the new electronic system had been implemented some two years ago, not all known risks were recorded on the system. This meant staff were potentially at risk of visiting patients without full information. Senior staff we spoke with were not aware of this issue and said all information had been transferred across.

Are services responsive to people's needs?

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

Summary

We found:

- Staff were aware of the complaints system and knew how to manage complaints raised by patients and how to escalate concerns if required.

However

- There was an inconsistent approach to reporting and monitoring complaints.
- A thematic review carried out for the complaints received between January and March 2016 identified repeated assessments, cancelled appointments and delays in treatment.
- There was a lack of accountability to ensure completion of learning outcomes from individual complaints.
- Complaints and learning from complaints were not regularly reported on at meetings

Planning and delivering services which meet people's needs

- This section was not included as part of the focused inspection.

Equality and diversity

- This section was not included as part of the focused inspection.

Meeting the needs of people in vulnerable circumstances

- This section was not included as part of the focused inspection.

Access to the right care at the right time

This section was not included as part of the focused inspection.

Complaints handling and learning from feedback

- There was a policy and framework around the management of the complaints process, which defined the process for investigating and resolving complaints.
- The staff we spoke with were all aware of the complaints system within the organisation. They were able to explain what they would do when concerns were raised. Staff told us they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy they would be directed to their manager or the complaints process.
- Patients were actively encouraged to leave comments and feedback via the patient feedback form. In the podiatry clinic comments and complaints leaflets containing information about the process were available in the waiting area and reception for patients who wished to make formal complaints.
- There was no comprehensive assurance system to ensure performance measures were monitored and that action was taken to improve performance. We observed the same themes emerging from the complaints report from 2014/2015, 2015/2016 and 2016/2017. These trends were around clinical treatment and appointments, cancellations and delays. We also observed, during a community nursing team meeting that we attended, further reminders to staff, to communicate with patients about appointments and visits.
- There was an inconsistent approach to reporting on and monitoring complaints. Complaints and their learning outcomes were not reported on regularly at quality and governance meetings, as set out in the complaints policy. The policy stated that complaints should be discussed monthly at the achieving quality meeting. The customer service manager told us that complaint reports were only presented 'periodically'.
- We observed the minutes from the achieving quality meetings for the last six months from January 2016 to August 2016. Complaints only featured in two out of the six meetings. At February's meeting, emphasis was placed upon how learning from complaints could be look at further to improve services; however this was not followed up at the meeting in March. The March minutes identified an increase in complaints for the community nursing team from the previous year but there was no discussion around learning from any complaints at either meeting. The customer service lead told us that the number of complaints had reduced from April 2016. However, from the data provided we noted a spike in complaints in May 2016. This had not been noticed or any action taken to address the increase.

Are services responsive to people's needs?

- The district nursing team had received 124 complaints during the period from April 2015 to the end of March 2016. This represented a 238% increase on the previous year. More recent data showed a total of 39 complaints for the period January to June 2016 with monthly totals peaking at 23 in February and reducing to eight in June.
- A thematic report was produced for all the complaints received in Quarter 4 (January to March 2016). The themes identified included repeated assessments, cancelled appointments and delays in treatment and had in part been attributed to the scheduling difficulties following the introduction of the new electronic record system.
- There was a lack of accountability to ensure completion of learning outcomes from individual complaints. Outcomes and learning opportunities of complaints were required to be recorded in the appropriate section of the process form. The complaints policy stated that these had to be signed off and dated on completion. We reviewed five closed complaints between June and August 2015. Despite a drive to encourage managers to complete this section, only one of the forms had been completed by the business manager of the appropriate department. The customer service lead was unable to provide us with an explanation as to why the policy criteria had not been fulfilled and why this had not been followed up.
- The customer services manager planned to carry out a survey of complainants to obtain their feedback about the process.

Are services well-led?

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

Summary

We found:

- There was a lack of accountability to complete processes to identify learning outcomes from complaints and incidents. Incidents and complaints were not regularly reported on at senior management meetings.
- There were inconsistencies amongst the leaders of the community nursing team with regards to the quality and depth of feedback provided about incidents at team meetings, how performance issues were addressed.
- Community nurses felt disconnected from senior management.
- Concerns within the organisation had not been highlighted on the risk register. This included staffing levels, incidences of pressure damage and the issues with the electronic records system.
- Staff did not consistently receive supervision, clinical supervision or appraisals.

However,

- Staff in the podiatry department felt valued, respected and listened to.
- Leaders in the podiatry department understood the importance of staff engagement to improve the quality of the service provided.
- Team meetings took place regularly to ensure staff were aware of organisational updates and relevant information.

The culture of the organisation and the staff who worked there was one of a committed workforce, who strived to provide a caring and compassionate service.

Vision and strategy

- This section was not included as part of the focused inspection due to the organisation ceasing to provide the services after 1 October 2016. **There was a plan for the management of the services to be transferred to Great Western NHS Foundation Trust from 1 October 2016.**

Governance, risk management and quality measurement

- There was a framework for clinical governance which covered external and internal audit, quality monitoring and initiatives, safety, performance development and sustainability, strategy implementation and service development.
- Clinical policies and guidelines were available for all staff via the trust intranet system.
- There was no arrangement in place to ensure adherence to policies and procedures following incident reporting, or that actions were monitored to ensure they were implemented and embedded into practice. There was inconsistent completion of actions, learning outcomes and processes to monitor and evaluate that actions were implemented following incident reporting. We observed incomplete incident reporting forms and serious incident reports. We also observed a serious incident report from the reporting period of April to July 2016. The report contained information about learning outcomes and actions from each serious incident, but no further information about who was monitoring these actions or time frames for implementation and review. All of the staff we spoke with including directors of the board, associate directors and operational staff, said they identified that staffing was a high risk to the organisation. However, this had not been recorded on the risk register. Other risks identified by staff such as the electronic records system, pressure damage and patient falls were not recorded on the organisations risk registers.
- Information was not provided by the service to give assurance that there was a system for identifying, recording and managing risks. A strategic risk register was provided however this contained risks associated with the business. We were not provided with a clinical risk register. This provided no assurance around what risks were escalated onto the clinical risk register and the mitigating actions taken.
- The SWIPE wound audit had been carried out and the outcomes from the audit provided learning

opportunities for staff. Lead clinicians from SEQOL and other organisations involved in the project were included in presenting information and providing training to all staff.

- Concerns had been raised about the community nursing service. For example, the prevalence of pressure damage and missed or late visits. An external review of the service had resulted in an action plan which identified a number of areas for improvement. A community work programme had been set up to address these shortfalls and was reported to the local clinical commissioning group. Assurances from this programme were reported to the board through a weekly meeting, to which senior staff within the organisation attended.
- Weekly team meetings and monthly whole team meetings were held by the community nursing teams and provided a forum for discussion of topics covering service delivery, quality and development. The meetings were attended and chaired by the community matron and all trained nurses and nursing assistants attended. There was a standard agenda which covered feedback from incidents and complaints, training and competencies, pressure ulcers, tissue viability, annual leave and sickness, with extra topics covered at the monthly meeting as required. Staff were also given the opportunity to raise issues or concerns at the meeting.
- Due to a number of experienced and district nurse qualified staff leaving the organisation, there were only four members of staff who had the district nursing qualification. This training had not been provided in Swindon for a number of years which had led to a lack of suitably skilled and qualified district nurses. The organisation had addressed this by enabling staff to attend modular training relevant to their role as community nurses.

Leadership of this service

- The chief executive and other board members were visible to staff in the organisation, had attended team meetings and met with staff. The community nursing services were led by the associate director for quality, who also had the responsibility of professional lead for the organisation. There was a structure within the community nursing service with matrons and senior nurses supporting the teams, which were led by band six sisters. The teams consisted of registered nurses, paramedics and health care assistants. However, several nurses from the community nursing team said that they felt disconnected from leaders at executive level despite them being visible within the organisation. They felt well supported by their immediate line managers, but there was a lack of support and representation for managers at a higher level regarding issues raised by nursing staff working on the ground.
- Recurrent trends and themes around incidents and complaints questioned the ability of the leaders to lead effectively at different levels within the organisation. Repetitive incidents such as pressure ulcers and complaints themes, demonstrated that leaders were unable to effectively address quality, performance and service delivery issues.
- The importance of completing procedures according to policy and the identification of learning outcomes was not embedded into the culture of the service. We observed several incomplete complaint and incident reports. This questioned whether learning from lower harm incidents was identified and feedback to staff to improve quality and service delivery.
- The community nurses were located in the same building as the executive board members. We were told there was daily interaction with staff to ensure teams were safe and there were no issues which required action from senior managers. However, not all community nursing staff confirmed this and said they did not always attend the office, as they met elsewhere.
- Each week a leadership meeting was held. This was attended by all lead clinicians such as specialist nurses, community matrons, the business manager and associate directory for quality. At this meeting caseloads and staffing levels were reviewed for the forthcoming week. Action was taken when concerns were identified. For example, booking of agency staff. The week prior to our inspection, access to the community nursing service had been ceased for new patients as the teams did not have the capacity to provide new episodes of care or treatment safely.
- The community nursing service was provided throughout the 24 hours. The night staff were based in the urgent care centre within the acute hospital site. The community night nursing team were managed by the urgent care centre team and not through the daytime community nursing service. We were told, staff who worked within the night service had experienced a number of changes of managers within the last two

years. One member of staff told us their previous manager had left approximately three months ago, but that they had not met their new manager. They were aware of their name but not when, or how they worked, whilst other staff we spoke with knew who their managers were, with one reporting that they saw their manager recently at a training session they attended during the day.

- The tissue viability service facilitated learning and education support for community nurses by undertaking joint visits with community nursing staff. The outcomes of the meetings were used as a means for education, support and care planning.
- In podiatry the managers were an experienced and strong team with a commitment to the patients who used the service and also to their staff and each other. They were visible and available to staff and we saw and heard about good support for members of the team. We received positive feedback from staff who had high regard and respect for their managers.
- The podiatry team lead understood the challenges faced by the team. The clinical lead was new into post in December 2015 and had identified that the department was not capturing any learning outcomes from complaints or incidents. With support of the clinical team, a project improvement plan had been designed to address weaker areas of the services and actions identified to improve the quality of the service provided. This action plans were ongoing at the time of our inspection and included the following streams: service delivery, process review and improvement, people development, quality assurance, leadership and communication, cost and benefits.
- Most staff in the district nursing team had not received an appraisal during the last year. The figures provided by the organisation showed a compliance rate of 4.5% during the last 12 months. Of the 11 members of staff we spoke with, two had received an appraisal within the last month, with a further two within the last two months. In podiatry compliance was at 100% for the same period. One member of staff we spoke with who regularly worked alone stated they had not had an appraisal for four years. Some of the night staff said they had recently received an appraisal and had supervision on a flexible basis and could decide how often they required this. All of the night staff we spoke with felt very supported by the urgent care team, other clinicians and GPs they worked with during the night shift.
- Staff from the community nursing teams we spoke with said they did not receive formal supervision. Staff said they communicated regularly with their direct line managers, but seldom had the opportunity to do so with managers at a higher level.
- A programme of supervision and dedicated leadership sessions had been set up from senior band 7 nurses for the band 6 community sisters in July 2016. Supervision sessions had been planned for band 5 registered nurses with some having taken place. We spoke with a community nursing sister who said it was a priority to provide newly registered or appointed nurses with supervision and support as this had been lacking.

Culture within this service

- Board members we spoke with made positive comments about the staff working within the organisation. Specific comments included “they are good staff who go the extra mile”. The managers we spoke with told us they were proud of the staff they supervised and that there was a high level of commitment to providing quality services to the community. One member of the district nursing team said “although I feel stretched … we are a close-knit team and do the best we can.” In podiatry there was a similar culture of support for each other. Staff we spoke with said they were proud to work within their teams and were passionate about the care they provided.
- The culture in the teams encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. Most staff felt comfortable about raising any concerns with their manager and staff told us they were not frightened or worried to talk to their manager if something had not gone as planned.
- Staff in the podiatry department felt that their ideas for service improvement were respected and valued. Staff we spoke with reported that they felt listened to and were encouraged and invited to provide feedback and ideas for service improvement. This happened through the use of regular emails sent out to staff and discussions at team meetings. Staff gave us examples of ideas they had suggested regarding the restructuring of clinics. This feedback had been taken on board and was in the process of being arranged. Staff said they felt part of a joined up team with a positive working culture.
- The podiatry team worked collaboratively and constructively and shared the responsibility to deliver good quality care. The clinical team were involved with

restructuring service delivery. Clinicians were empowered to identify shortfalls within the system and identify actions to improve service delivery. Actions were then implemented into practice and were the responsibility of each individual team member to carry out and embed into service delivery. The staff we spoke with were positive about being involved with the change and felt that the new ways of working had improved the service.

- The community nursing teams were patient centred with individual staff working well together to provide a caring and compassionate service to patients. Staff we accompanied on visits and spoke with showed empathy and understanding to and about their patients.
- The community nursing staff who attended a group meeting with us during the inspection said they were most proud of managing a heavy workload, whilst another member of staff reported to be most proud of the provision provided at night by the community nursing team.
- The community nurses working at night felt disconnected from the team that worked during the day. The nurses felt that no effective communication links had been established and no working relationships had been established despite being part of the same team. The night nurses did not attend the monthly team meetings and said they found out about changes to ways of working and other information via email, when they had time to access these. Patients they visited also informed them of any changes made to their care by the day team of nurses.

Public engagement

- There was system to engage with the public to ensure regular feedback on services. Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The results of the survey were used to improve the service and covered the patient's overall satisfaction of their experience and how likely they were to recommend the service to friends and family if they needed similar care and treatment. Results were consistently high for the last 12 months, with most patients saying they would recommend the services. Patients were asked to rate the service on a scale of one to five and results for both podiatry and community nursing were consistently high.
- For district nursing, recurring phrases were captured including "friendly", "caring", "nurses are great" and "convenient." Within the survey, patients were asked what their 'just one change' to the service would be. Comments included; "regular times of visits", "to be told a time of visits", "same nurse visiting each time" and "better communication."
- For the podiatry service, comments from patients included the phrases "professional", "good at their job", "very informative" and "very friendly welcoming staff. Suggestions for 'just one change' to the service included "temperature in clinics", "long wait for appointments" and "brighten dated interior of buildings."

Staff engagement

- Staff were provided with organisational updates from a whole staff group weekly newsletter, access to the organisations intranet facility and through a social media site.
- Staff in podiatry had been engaged in a restructure of processes and procedures following complaints raised and concerns about aspects of service delivery in the department, for example, paper referrals, clinic appointments, follow up clinic appointments and discharging patients. A departmental meeting had been held which included clinical and administrative staff, where the patient journey had been mapped and ideas discussed on how to improve the patient's experience. Staff said their thoughts and recommendations had informed process and tools to deliver the service. This had led to new standard operating procedures being embedded into practice. They felt that the service had become more streamlined and efficient.
- The tissue viability team held a weekly team meeting which enabled review of the operational caseload, management and clinical supervision. Each fortnight, the team meeting was attended by the business manager responsible for the service, who was able to update the team with any organisation wide updates or feedback.
- The community night nursing team showed us the minutes of their last team meeting which had taken place in March 2016. An action plan had been produced as a result of the meeting, but staff said this had not been reviewed and the actions not addressed. Since the meeting, there had been a change of manager of the service.
- The organisation conducted an annual staff survey. This survey included 10 questions for staff to answer and the ability to include a narrative as required by individuals.

Are services well-led?

We were told that the findings from the 2015-2016 survey showed that staff would recommend the organisation as an employer and to receive care and treatment from. We did not see the completed survey.

Innovation, improvement and sustainability

- The organisation had identified that there had been an issue with patients experiencing pressure damage. As a result a project had been developed which was based on incidents and subsequent learning. The outcome from the project had been formulated into a report which was due to be presented to the board meeting in September 2016. Actions had already taken place as a result of the project such as additional training for staff.
- The organisation was to cease to run community services, as the tender had been awarded to another organisation by the local commissioning group. Despite the uncertainties about the future of the service, most staff were prepared for change and continued to be committed to provide high-quality care. They felt there was scope and a willingness amongst the team to develop services.
- Due to the shortages of staff within community nursing teams, the organisation had employed a number of paramedics to carry out assessments and provide urgent care and treatment to patients. This enabled district nurses to prioritise patients with complex care and treatment needs.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) Care and treatment must be provided in a safe way for service users. 12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include (a) assessing the risks to the health and safety of service users of receiving the care and treatment (b) doing all that is reasonably practicable to mitigate any such risks (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs. 12 (2) (a) Patient care records and risk assessments were not completed fully and were not consistently up-to-date. Patient confidentiality was not maintained as names were recored in meeting minutes which could be accessed. 12 (2) (b) Due to the limited access to the electronic records system when in the community, nurses were not always aware of the recommended care and treatment for all patients. Staff said they were not consistently provided with feedback on incidents they reported. There were inconsistencies between the quality of the feedback provided around incidents at the community nurse meetings. During our inspection we visited the homes of five patients and found that their care and risk assessment

This section is primarily information for the provider

Requirement notices

documentation was not up-to-date. We saw incomplete records regarding equipment that was in use in patient's homes. Risk assessments did not reflect all equipment that was in use.

12 (2) (f)

At the time of our inspection, staff told us that the dressings available did not always meet the needs of patients. For example, we observed the care and treatment for one patient and observed that the dressings available were not large enough to cover the wound.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (2) Systems and processes must be established and operated effectively to prevent abuse of service users 13 (2) The safeguarding lead reviewed all safeguarding referrals made through the organisation's electronic reporting system, no monitoring had been carried out to identify any patterns or themes.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints 16 (2) The registered person must establish and operate an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. 16 (2) There was an inconsistent approach to reporting on and monitoring complaints. Complaints and their learning outcomes were not reported on regularly and at quality governance meetings as set out in the complaints policy.

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Requirement notices

The policy stated that complaints should be discussed monthly at the achieving quality meeting. The customer service manager told us that the complaints reports were only presented 'periodically.'

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems of processes must enable the registered person, in particular, to- (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying on of the regulated activity (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely 17 (2) (a) We observed the minutes from the achieving quality meetings for the last six months from January 2016 to August 2016. The July 2016 meeting had been cancelled. Complaints only featured in two out of the six meetings.

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Requirement notices

17 (2) (b)

There was no arrangement in place to ensure adherence to policies and procedures following incident reporting, or that actions were monitored to ensure they were implemented and embedded into practice. There was inconsistent completion of actions, learning outcomes and processes to monitor and evaluate that actions were implemented following incident reporting. We observed incomplete incident reporting forms and serious incident reports.

17 (2) (c)

We reviewed 11 records and found the care, treatment and risk assessment records were not completed fully and were not consistently up to date The inability to access the patient's electronic records put staff at risk of not being aware of the most up-to-date care and treatment plans and risk assessments for their patients.

Patients were discussed and records of the discussions were contained in the community nursing team meeting minutes. The weekly minutes contained the names of patients and discussions about them and their current status. This process did not support the confidentiality of the patients using the service and conflicted with the Data Protection Act of 1998.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. 18(1) Sufficient numbers of qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of the Part 18(2) Persons employed by the service provider in the provision of a regulated activity must –

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Requirement notices

(a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

(b) Be enabled where appropriate to obtain further qualifications, appropriate to the work they perform

18 (1)

The service had 6.65 whole time equivalent nursing staff vacancies which equated to 10% of the community adult workforce Data provided by the trust showed that the community nurses consistently carried out a higher number of contacts with patients than the target agreed with the contract with the commissioners. We were told the organisation was not using an acuity tool at the time of our inspection therefore this did not enable them to measure and assess staffing levels appropriately.

18 (2) (a)

Most staff in the district nursing team had not received an appraisal during the last year. The figures provided by the organisation showed a compliance rate of 4.5% during the last 12 months.

There were deficits in training and education in the adult community nursing team. Several staff said that training was not consistently delivered to meet their needs and that they were not able to access training as they needed it.

There was poor compliance with completion of community nurses' yearly appraisals and inconsistent supervision and one to one support.

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Requirement notices

There were only four members of staff in the community nursing team who had obtained the district nursing qualification.

Some permanent staff had not completed the incident reporting training at the time of our inspection. This meant that not all staff were able to identify when an incident had occurred, assess the severity or know how to instigate a report.