Staffordshire & Stoke-on-Trent Partnership NHS Trust

R1E

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)
R1EG3	Staffordshire and Stoke-on-Trent Partnership NHS Trust - HQ	Community adult nursing	various sites over Staffordshire

This report describes our judgement of the quality of care provided within this core service by Staffordshire & Stoke-on-Trent Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Staffordshire & Stoke-on-Trent Partnership NHS Trust and these are brought together to inform our overall judgement of Staffordshire & Stoke-on-Trent Partnership NHS Trust

Summary of findings

Ratings

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

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Overall summary

Good

Overall rating for this core service

When we last inspected this core service in 2015 we found that the trust were in breach of a number of Regulations. These breaches meant people had been or had been at risk of receiving unsafe, ineffective and unresponsive care. At that time, effective systems were not in place to ensure the service was consistently well-led. At that inspection, we rated the core service as inadequate and we served a Warning Notice to the Trust on 15 December 2015 informing the trust of the improvements they were required to make.

At this inspection, we focussed on how community nursing services operated within the trust as the concerns we found at our previous inspection mostly centred around these services.

At this inspection, we found significant improvements had been made and we identified no regulatory breaches. We found that:

- Incidents were reported, investigated and learnt from across the trust.

- Staff understanding of the duty of candour was much improved since the previous CQC inspection in 2015 (the duty of candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things go wrong).
- Staffing levels were sufficient to keep patients safe.
- Medicines were recorded and administered as per national guidelines.
- Patient records were, in the majority, well completed and contained sufficient information to keep patients' safe.
- Patients received care and treatment that was evidenced based and met best practice guidelines.
- Staff was appropriately qualified and competent at the right level to provide the care that patients required.
- There were improved arrangements for staff supervision and appraisal.
- There was a multidisciplinary collaborative approach to care and treatment.

- There were appropriate systems in place to monitor and improve quality and patient outcomes.
- Staff could access the information they needed to assess, plan and deliver care to patients in a timely way.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005.
- We found that the trust used do not attempt cardio pulmonary resuscitation (DNACPR) records and staff had appropriately completed them.
- People were supported and treated with dignity and respect and they were involved as partners in their care.
- Staff provided people and their families/carers with emotional support and promoted self-care and independence where possible
- Feedback from people who used community nursing services was positive about the way they had been treated by staff.
- We observed caring and compassionate interactions between patients and we saw that staff were consistently respectful and kind.
- Suitable leadership structures were in place to provide staff with the support and guidance they required.
- Staff described their team leaders and managers as approachable and accessible.
- Staff shared and followed the trusts values, vision and strategy to promote patient centred, high quality care.
- Effective systems were in place to ensure that patient safety and the quality of care was consistently assessed, monitored and managed to ensure safe and effective care was delivered.
- We found a positive shift in staff culture. Staff felt able to report safety concerns and felt empowered to make innovative changes to the way they worked to improve patient care and staff morale.

However;

- We saw some examples whereby patient care plans were incomplete or had not been updated appropriately. Furthermore, we saw that within the majority of records we looked at, demographic information had not been consistently completed.

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- During this inspection, we found that mandatory training compliance varied between areas as of March 2018. In particular we saw compliance against the trust targets for fire safety training and basic life support training was consistently not met in all community nursing teams. Overall, mandatory training compliance was lower within community nursing teams located within North Staffordshire than those located within South Staffordshire.

- Some investigation reports following incidents that had caused moderate harm to patients did not have an action plan attached to show how future harm could be prevented.

Summary of findings

Background to the service

Staffordshire and Stoke-on-Trent Partnership NHS Trust delivers a wide range of community health and adult social care services across a diverse population of over 1.1 million within the geographical boundaries of Staffordshire County Council and Stoke on Trent City Council, covering both urban and rural areas.

For adult community services we inspected the regulated activities across 12 teams within Staffordshire that provided community adult nursing under the trusts registration. The nursing teams we visited were based at; Rising Brook Health Centre (Stafford), Greyfriars Therapy Centre (Stafford), Moorlands House (Leek), Milehouse Primary Care Centre (Newcastle under Lyme), Wombourne Clinic (Wombourne), Bilbrook House (Codsall), Sandylane Health Centre (Rugeley), Meir Primary Care Centre (Stoke on Trent), Bentilee Neighbourhood Centre (Stoke on Trent) and Merlin House (Tamworth). Some of these bases hosted more than one team. Each team or service had a team leader who provided day-to-day operational leadership. The team leads were managed by neighbourhood managers who were in turn managed by area managers.

Services we inspected were provided in people's own homes, residential homes and within clinics.

During the two weeks leading up to our inspection we held seven staff focus groups where we spoke with a total of 54 members of community nursing staff from across Staffordshire.

During our inspection, we spoke with 27 patients, 14 carers or relatives and 51 community based staff (including administrators, nurses, therapists and community nursing managers). We also spoke with the Director of Nursing and the Head of Quality Governance. We looked at 45 sets of patient records.

The trusts community nursing teams completed 614705 face to face contacts between 1 March 2017 and 28 February 2018. 583482 visits were made between 8am and 6pm and 37413 of these visits were made between 6pm and 8am. A total of 31223 patients received care from community nursing teams in same time frame.

There had been recent changes to the service with a separation of social care staff from within the teams.

Our inspection team

Our inspection team was led by an inspection manager. The team included CQC inspectors and a variety of specialists, including; community nurses, a community matron and nurses with a specialist interest in end of life care.

Why we carried out this inspection

This inspection was carried out using CQC's focused inspection methodology. A focused is more targeted looking at specific concerns rather than gathering a holistic view across a service or provider.

The focused inspection was triggered by the merger of the trust with South Staffordshire and Shropshire NHS

Foundation Trust to form Midlands Partnership NHS Foundation Trust on 1 June 2018 and also to review the issues identified in the Warning Notice issued on 15 December 2015.

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How we carried out this inspection

We inspected the two core services that had previously been rated as 'inadequate' at our November 2015 inspection. These core services were 'Community Health Services for Adults' and 'End of Life Care'.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out a short notice announced visit on 18 and 19 April 2018.

We did not hold a public listening event prior to this inspection as this was a short notice inspection, however we met with Staffordshire Healthwatch and Stoke Healthwatch to seek any feedback that people had shared with them about the trust.

During the inspection we met with 53 members of staff. This included, the Director of Nursing, service managers and leaders and clinical staff of all grades.

Prior to the visit we held seven focus groups with community nursing staff across Staffordshire who worked within the service. 54 staff attended those meetings and shared their views.

We visited 12 community nursing teams and we observed direct patient care and treatment. We talked with 27 people who used services. We observed how people were being cared for and talked with 14 carers and/or family members and reviewed care or treatment records of 45 people who used services.

What people who use the provider say

- People spoke very positively about the care they received from the community nursing staff. This positive feedback was reinforced by the Family and Friends Test which well exceeded the national target of 90%. The trust data for April 2017 to March 2018 showed that 99% of 7515 patients in the North and 98% of 8638 patients in the South would recommend services run by the trust to their friends and family. These figures related to all community services operated by the trust.

- Trust data showed that between April 2017 and March 2018 7108 compliments had been received relating to the provision of community services. This showed that these people were very satisfied with their care.

Good practice

- The trust designed and developed a District Nurse Caseload Review Tool that was launched in February 2017. This tool has created standardised approach to reviewing district nurse caseloads. The tool ensured that all district nursing caseloads were managed and ran efficiently and effectively. The tool was awarded first prize and praised for its innovative approach at the Queen's Nursing Institute Annual Conference in October 2017 and had been shortlisted for a 2018 Health Service Journal Values Award.

- Wellbeing cafes had been set up in conjunction with local councils within South Staffordshire. These had run for six months at the time of the inspection; and were scheduled for a further six months. These cafes

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provided education and support to patients with long term conditions enabling them to remain independent and managed within community

services for longer. Staff had worked with voluntary agencies to assist patients to access transport services to enable them to attend ambulatory clinics where appropriate.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

- The trust should ensure the lone working policy is embedded and followed by all staff working in the community to promote their safety and wellbeing.

- The trust should ensure patient records are consistently completed fully; with documented reasons for why any assessments/ sections are not filled out.

- The trust should ensure that when incident records document that a safeguarding referral is required, this should be evidenced as been completed in the incident documentation.

- The trust should ensure mandatory training levels are consistently achieved and sustained.

Staffordshire & Stoke-on-Trent Partnership NHS Trust

Community health services for adults

Detailed findings from this inspection

Good 🟢

Are services safe?

By safe, we mean that people are protected from abuse

Summary

At our last inspection, this domain was rated as inadequate. This was because:

- The systems for assessing staffing levels was ineffective and there were substantial staff shortages affecting the ability to provide safe care.
- Robust handover systems were not in place to ensure important information relating to patient care was handed over effectively.
- Staff were not always able to demonstrate their responsibilities under the Duty of Candour regulations.
- Effective systems were not in place to ensure learning from incidents was shared and embedded.
- Medicines were not always stored securely
- Patient records were not always updated with accurate information.

At this inspection, we found that improvements had been made and we have now rated safe as good because:

- We saw that incidents were reported, investigated and learnt from across the trust. All staff we spoke with were familiar with the electronic incident reporting system; and could describe learning following previous incidents.
- Staff understanding of the duty of candour was much improved since the previous CQC inspection in 2015 (the duty of candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things go wrong). We saw examples of the duty of candour being applied in order to work transparently with patients and to learn from mistakes.
- Since the last CQC inspection in 2015; we saw that staffing levels were sufficient to keep patients safe. Whilst we saw some vacancies within teams, these were well managed using the trust escalation policy for staffing.
- Medicines were recorded and administered as per national guidelines. Nursing staff did not carry

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medicines; but administered patients' own medicine. The medicine management team within the trust conducted yearly audits to ensure compliance to safe practice.

- Patient records were, in the majority, well completed and contained sufficient information to keep patients' safe which was an improvement following the previous CQC inspection in 2015. We saw some examples whereby care plans were incomplete or had not been updated appropriately. Furthermore, we saw that within the majority of records we looked at, demographic information had not been consistently completed.

However;

- During this inspection, we found that mandatory training compliance varied between areas as of March 2018. In particular we saw compliance against trust targets fire safety training and basic life support training was consistently not met in all community nursing teams. However; we saw robust plans to manage this area of concern.
- Three investigation reports following incidents (pressure ulcers) that had caused moderate harm to patients did not have an action plan attached. These were all from a specific area; Stafford.
- We saw one investigation report where staff should have considered the need to make a safeguarding referral; however, this was not documented as discussed or set as an action within the report. Therefore, there is no record as to how this risk was managed.

Detailed findings

Safety performance

- The safety thermometer check was conducted one day per month. The safety thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs. Data was collected by district nurses and collated by administrative staff. Team leaders had monthly oversight. We saw that recent results were 'green' (met targets for harm free care of 95%) and 'amber' (mostly harm free care). Results were shared with staff to promote learning and improvement.
- Data from the trust showed that between December 2017 and February 2018, across eight community nursing bases, harm free care ranged from 100% to 89%.

The highest levels of harm free care were seen in Seisdon whereby 100% of patients were harm free within December 2016, January and February 2017. The lowest levels of harm free care were Tamworth West who varied between 100% harm free care to 89%.

Incident reporting, learning and improvement

- Data from the trust showed that between March 2017 and February 2018, 6506 incidents were reported. We saw that all these incidents were categorised as '0', '1', '2' or '3' except for one which was graded '4' None had been categorised '5'. (0 refers to a near miss, one refers to no harm caused, two refers to minor harm and three is moderate harm/ non-permanent impact. Four and five refer to major harm/ permanent impact and death respectively). The incident categorised as major harm occurred in the community intervention service in Lichfield and Tamworth during August 2017 and related to computer connection failures over a period of time. Information provided from the trust indicated that the 'major harm' was more likely to be business related rather than direct patient harm.

- We saw that the most reported type of incident in general was pressure ulcers; with the majority of serious incidents investigated also regarding pressure ulcers. Trust data showed that between December 2017 and February 2018 a total of 951 acquired pressure ulcers were reported by community nursing teams. 484 were classified as grade two, 155 were classified as grade three and seven were classified as grade four. The trust data evidenced that the numbers of reported pressure ulcers were closely monitored and analysed to ensure avoidable pressure ulcers were identified so that action could be taken to reduce the risk of further preventable incidents from occurring. The number of avoidable pressure ulcers was low. For example in the North only eight of 168 pressure ulcers investigated and reviewed by the Pressure Ulcer Review Group were classed as avoidable. Staff told us that learning from these avoidable incidents was shared with them.

- Monthly risk reports were produced for each local area which explored incidents reported, trends, investigation outcomes, actions and any requirement for duty of candour. The duty of candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things

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go wrong. We reviewed a sample of these reports between December 2017 and February 2018 and found these reports to be robustly investigated, included patient involvement with a letter of apology where appropriate. There was a good level of shared learning information disseminated for staff working directly with patients.

- We saw a recently returned root cause analysis and associated action plan at one district nursing base for a deep pressure ulcer within South Staffordshire. Although the pressure ulcer was deemed to be 'unavoidable'. actions were identified for staff to promote learning and best practice in future. Further root cause analysis reports provided by the trust showed thorough investigations; with completed action plans and lessons learnt documented. However, we viewed three root cause analysis documents from Stafford which had blank action plans attached. In addition, despite one of these investigations finding that a delay of carers in informing district nurses had exacerbated the pressure ulcer; there was no reference to a safeguarding referral being made.

- Staff we spoke with were aware of investigations into recent incidents. For example, staff could articulate actions following investigations into serious pressure ulcers as above. In addition; a nurse explained to us and we saw how, as a result of an incident, a carry bag had been provided by the trust so that nurses could carry patient's notes more securely ensuring confidentiality.

- Staff reported incidents using an online incident reporting tool. All staff had access to this and were familiar with how to use it. Following the reporting of an incident; team leaders triaged these to identify the level of risk and harm. If a reported incident met the threshold; they would be referred to the relevant risk team within the trust for further investigation. For example, pressure ulcers assessed at grade three or over were referred to the 'pressure ulcer risk group'.

- During our previous inspection staff said they did not receive feedback from incidents. However during this inspection staff mostly told us they did receive feedback. Staff told us they received an acknowledgement email from their manager following the submission of incidents. General learning from

incidents across the trust was shared at team meetings and via email. Any urgent messages following on from incidents were discussed at the first available opportunity such as the daily handover.

Duty of candour

- The duty of candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things go wrong.

- During our previous inspection we found that there was mixed understanding amongst community staff (therapists, community nurses and community intervention service staff) about 'Duty of Candour'. During this inspection we found that staff were aware of the duty of candour and understood the principles of this. Regular reports were produced which identified the number of incidents that had triggered the duty of candour each month. In addition, we saw copies of duty of candour reports for the trust dated between December 2017 and February 2018. These highlighted on how many occasions the duty of candour had been carried out each month (20 in December, 33 in January and 27 in February); and reported upon any situation where it had not been possible to complete this duty in full. For example, if a patient did not have capacity to understand the duty of candour process in addition to having no family members to report to. Learning points which arose from following the duty of candour were shared with staff.

- During our inspection, whilst conducting a patient visit observation we saw that a patient had developed skin damage after the patient's leg had become swollen and subsequently a bandage had become tight. The community nurse apologised to the patient, explained the actions they would undertake which included removing the old dressing and ordering new dressings which would better fit the patient's needs. They explained that the patient would also receive a letter explaining all actions to be undertaken. When the community nurse returned to the base they completed an incident report and made the team leader aware that the patient had sustained pressure damage.

- We looked at ten root cause analysis reports and saw it was clear as to how, when and by whom the duty of candour had been carried out. Any additional comments; such as patients who declined written

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documentation pertaining to duty of candour were clearly documented and dated. We also saw copies of initial duty of candour letters sent to patients and patients' next of kin where appropriate in addition to detailed follow up letters explaining investigation outcomes and an apology?

- During this inspection we found that the majority of staff met the trust training target for duty of candour; across the trust; the compliance was 95.4%. Only one community nursing team had not met the trust target; Newcastle, North Staffordshire who achieved 79% as of March 2018. However, within this team, we noted that all staff we spoke with had a good understanding of duty of candour and when it should be applied.

Safeguarding

- Data from the trust showed that between March 2017 and February 2018; 146 safeguarding referrals were made across all community nursing teams. The highest category of referrals fell under neglect (68 out of 146), and self-neglect (32 out of 146). The highest reporting teams included Cannock, Leek Moorlands, Stoke and Tamworth/ Lichfield who all made 13 referrals throughout the year.

- We saw evidence of a staff making an appropriate safeguarding referral; however, we also saw where a safeguarding referral should have been considered but this was not documented.

- Staff had access to the trust safeguarding team and also to social services. Staff worked in close contact with social services therefore were aware of the process of referring a safeguarding concern through either internal or external channels. For a patient was at immediate risk, staff told us they would report straight to the local safeguarding team, such as the Multi Agency Safeguarding Hub (MASH) and request an urgent assessment. Staff were also aware of their responsibility to call the police if a patient was at risk of being harmed.

- Staff who answered patient calls via the single point of access (SPA, also known as locality access point) referral centre understood what may constitute a safeguarding risk; and reported they sought advice from nursing staff in order to make a referral if necessary.

- Staff gave examples of patients where safeguarding concerns had been raised; which had resulted in a

multiagency approach to managing and reducing the risk to the patient. We saw that pathways to follow, including contact numbers, were displayed within community nursing offices.

- Staff were aware of the importance of reporting and recording what they may perceive as minor concerns, in order to ensure that no information is missed. Therefore, where necessary evidence could be gathered over time in order to build a 'bigger picture'.

- Overall, we saw that staff had met the trust training target of 90% for safeguarding adults at required levels; achieving 95.89% compliance overall.

Medicines

- Community nursing staff did not carry medicines, with the exception of anaphylactic kits. Patients sourced their own prescription medication via their GP and local pharmacy services. We saw that nurses gave advice on how to store medicines securely within the home; particularly when patients were using controlled drugs (controlled drugs are medicines which are controlled under the Misuse of Drugs legislation, such as morphine).

- The trust medicine management team managed the anaphylactic kits carried by nurses. If one was used; this would be replaced immediately. Staff monitored the expiry dates and these were replaced as necessary whether used or not. We saw medicine storage audit results from the year 2017/2018 which showed this was case across all community nursing teams within the trust.

- Trust data showed that within community nursing 91 medicines incidents were reported between December 2017 and February 2018.Staff told us that they were supported by managers and the medicines management team post medicines incidents. Staff told us and audit records showed that the medicines management team visited bases on a regular basis to complete medicines audits and to share learning following incidents relating to medicines.

- The medicine management teams conducted audits of medicine storage and patient group directions (Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription)

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following recommendations from the previous CQC inspection in 2015. We saw the audit results from 2017/2018 which highlighted varying practice. In some areas; all teams showed full compliance; such as having an up to date version of the trust medicines management policy on site. However we saw some areas of non-compliance such as having a sign sheet to ensure all staff had read and understood the standard operating procedure for the management of medicines. On the whole, we saw that teams in the North of Staffordshire performed worse than teams in the South. For example, with regards to one audit criteria 'has the stock list been reviewed in the last year'; within the North only one team out of 10 was compliant. Within the South, five out of eight teams were compliant.

- We saw that action plans were in place to manage the areas in which areas were not compliant with the medicines storage audit requirements. The actions were due to be completed throughout 2018 and into 2019 so was an ongoing process at the time of inspection. Each action had a named responsible person to ensure compliance.

- Staff in a specific South Staffordshire community intervention team told us they used to have medicines at the base; kept in a lockable cabinet. However, this had been reviewed by the trust medicine management team a few months prior to the inspection and as a result had been de-commissioned to adhere to best practice within medicine management.

- Some nursing staff were qualified nurse prescribers; however, the majority of these staff only prescribed dressings and bandages as required; not creams or medicines. Prescription pads were kept securely in lockable areas.

- We observed staff administering patients' medicines within patient's own homes in line with prescription charts. Staff recorded this accurately and contemporaneously.

- We saw that where patients had problems accessing their prescription medicines through local pharmacies; staff were proactive in liaising with pharmacy staff and GPs to resolve these.

- Staff in Rugeley told us they were piloting a new scheme for storage of wound dressing. They explained that an agreed formulary for wound dressings had been

identified and were being kept centrally at the base. They said this enabled timely wound care treatment to be commenced without having to wait for a prescription to be issued by the GP and collected by the patient or their representative.

- Staff told us and we saw that there were monthly checks of patients controlled medicines which included anticipatory medicines which were escalated to the medicines management team. A manager told us that they not only checked the amount of medicines available and its expiry date they also checked that the medicine was appropriate. They explained this followed an incident whereby anticipatory medicines were no longer appropriate following a change in a patients' medical history.

Environment and equipment

- Patients were seen in a wide variety of locations throughout the trust ranging from health centres, residential homes and in their own homes. Equipment we looked at such as specialist pressure relieving mattresses and cushions (in patients' homes) had been appropriately calibrated and had received required safety checks.

- Nursing and therapy staff told us that they were able to request equipment for patients such as hospital beds, pressure relieving mattresses and commodes and they were received in a timely manner.

- Staff working in Stafford told us that they struggled for available working space. We observed within Greyfriars that staff had to share an office with another community team; this meant the office was noisy and confidential information shared within handover could be heard by staff who were not employed by the trust. We asked the staff how they managed this risk; they reported the spoke quietly and tried to sit separately for handovers.

- Staff told us and we saw that they carried a sharps box to ensure that needles and syringes were safely and appropriately disposed of. We observed correct disposal of sharps in all locations we visited. We observed that staff reported problems with patient held equipment. Staff used appropriate manual handling techniques within patients' home environments.

Are services safe?

Quality of records

- During the last inspection, we found that record keeping was inconsistent, variable and difficult to read. During this inspection, we found that there was a legible record within the patients' home of all visits that had been undertaken.

- Patient records and care plans were, in the main, paper based. Two copies were made of general nursing records. One remained in the patients' home and the other was kept securely at the relevant district nursing base. In total, we reviewed 43 records as part of the inspection. We saw these records were, in the main, kept in good order; with comprehensive care plans contained within. Entries made by nurses were up to date and clear.

- We found that in four records we looked at there was no revised plan of care available when the patients care or treatment had changed. For example, one patient required alternative management for their leg ulcers. We saw there was a record to say that alternative treatment was required and that the previous nurse had removed the plan of care to update it but no revised care plan was available. This meant that the community nurse who visited was not aware of the treatment required. This was raised with staff at the time of inspection; we returned the following day to find this patient record had been updated and revised.

- We also saw that the completion of certain parts of patient records had either not been consistently undertaken; or was missed with no reason as to why. For example, each patient was asked a series of demographic questions which formed part of their patient record. We noted that not every patient was asked every question; some questions were left blank even where there was an option to select 'prefer not to say'. Furthermore, parts of the trust assessment booklet were left blank. We saw that where this was done; it was due to the patient not requiring the clinical assessment; however this was not consistently documented. For example, one patient did not have a completed falls assessment. Although their presenting condition meant this assessment was not clinically required; the completing member of staff had not documented this

decision to forgo this particular assessment. Furthermore, we found dates and signatures missing from a small number of care plans including patient's signature and clinician's signature.

- Data from the trust showed audit results following reviews of patient records across the trust between 2016 to December 2017. We saw that recording demographic information, as discussed above was identified within the trust action plan in December 2017. However, this area of record keeping had showed improvement; for example, moving from 83% compliant for April to June 2017; to 90% within October to December 2017 against a trust target of 90%.

- The trust was in the process of moving to an electronic patient record. For the majority of trust teams; such as district nurses; only the initial referral details and each patient contact were recorded within these. However, some specific teams had moved to using these as an online record of care. All staff we spoke with were aware of which teams were using which form of record; and had the ability to access either paper or electronic records as necessary. Allied health professionals, including physiotherapists and occupational therapists maintained their own patient notes which were scanned and uploaded onto the electronic patient record.

Cleanliness, infection control and hygiene

- When entering a patient's home staff consistently showed adherence to infection control procedures. Staff washed their hands and used antibacterial gel before and after each contact. Staff were 'bare below the elbow' to enable effective hand washing and to prevent contamination; and wore appropriate personal protective equipment such as disposable gloves and aprons when providing patient care.

- We saw that not all staff had access to clinical waste bags within the community; therefore, were disposing of some articles in general waste; such as used PPE. We saw within the trust waste policy dated December 2017; staff should have access to clinical waste bags in which to dispose of certain healthcare related articles. We asked staff about this at the time of the inspection who did not know the trust policy regarding clinical waste bags.

- We saw that hand gel was available in clinics and community nurse bases and we observed it being used correctly.

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- Used equipment and dressings were disposed of on all occasions we observed care. Non-infected dressings were disposed of within domestic waste bins when they visited patients.

- All of the clinical environments we visited were visibly clean and dust free. We observed staff appropriately cleaned equipment when it had been used.

- Each team had an infection control link nurse. The link nurse's role included attending infection control meetings and providing feedback to their team. We saw this worked well in practice.

- Information provided by the trust showed that as of March 2018; only three of the four main teams based within North Staffordshire had achieved the trust training target in mandatory infection control training. However, every team with the South had met the trust target of at least 90% of staff trained.

- Results from hand hygiene audits between January to March 2018 showed that all but one team score 100% compliance. The team that did not achieve this were Kidsgrove within Newcastle who achieved 95% in January and 90% in March 2018. There were no results recorded for this team within February 2018.

Mandatory training

- New staff underwent a four week trust induction; in addition to a team specific community nursing induction which incorporated a set competency framework. This ensured community staff received training in mandatory areas in which they would be expected to work. For example, district nurses were required to undertake syringe driver training.

- We saw mandatory training compliance varied between areas as of March 2018. In particular we saw compliance against trust targets fire safety training and basic life support training was consistently not met in all community nursing teams. However, staff we spoke with were able to demonstrate an understanding of the requirements needed to keep people safe in the event of a medical emergency or fire.

- The trust were aware of the variances across teams with regards to mandatory training, and were actively working to address this. We saw plans following internal quality assurance inspections which confirmed the trust were actively taking steps to manage this.

Assessing and responding to patient risk

- Community based staff demonstrated awareness of key risks to patients such as urgency of patient visits. We observed that when risks or changes to clinical condition were identified contact was made with the patients GP or specialist nurses for alternative treatment such as antibiotics for infection, deterioration to a long-term health condition. Staff showed a clear knowledge and understanding of how to assess tissue damage; and the process for referral to tissue viability nurses.

- Community teams told us that they saw patients as soon as possible after a referral. First assessment appointments were prioritised based on individual risk and patient need. Staff told us that urgent cases would be seen within a few hours, less urgent first appointments would be seen within 24 hours unless there was a clinical need not too such as removal of sutures in five days. During the inspection we observed this was the case via observing patient visits.

- Staff working with patients recently discharged from hospital were aware of processes to escalate any concerns regarding deteriorating health.

- In the event of a patient deteriorating in health whilst a community nurse was present; staff responded based on the severity of the patient's health. For example, for more minor concerns staff could contact the shift lead (usually a senior nurse) for advice and guidance; or request a GP review. If a patient required more urgent assistance; a member of the community interventions team could be contacted to provide support; or the staff member could call the emergency services if the patient was acutely unwell.

- Staff could escalate or de-escalate patients to one of three teams depending on the acuity and level of care required. For example, district nurses cared for patients with short and long term health conditions; but lower acuity. Community matrons cared for patients who were diagnosed with long term health conditions who required more intensive input. The community intervention team (also known as community intervention service) cared for patients with high acuity; usually for shorter periods of time, with an aim to prevent hospital admission.

Are services safe?

- Risk assessments for falls, nutrition and moving and handling were completed and reviewed either at the identified frequency such as three months or when patients' conditions had changed.

- Where required, patients were checked for changes to their condition; such as via blood pressure tests and oxygen saturations. Some patients, following training, and/ or their carers took observations without the need for staff and provided these to their medical team for review.

- During the last inspection we found that there was not always a face to face handover between each shift as there were gaps in service provision between the end of the night shift and beginning of the day shift and at the end of the day shift till the start of the evening shift. We found during this inspection there was always an overlap in shifts which meant that staff could handover to each shift and when needed clarify the information about the patient and their needs.

Staffing levels and caseloads

- Staff told us they had previously been part of several smaller teams as seen at the previous CQC inspection in 2015. However, the smaller teams had merged into larger teams since then. Each large team had a team leader who was senior nurse manager (band 7). Within each large team were 'micro' teams which were attached to identified GP practices and lead by a senior staff nurse (band 6 nurses) who was the caseload holder. The band 6 nurses were the named nurse for the practice which gave the GP practice a named contact within then trust. This meant a better continuity of care for patients and staff benefitted from being part of a larger team to cover staff absence when required.

- District nurses worked between 9am and 5pm Monday to Friday, and 9am to 7pm on the weekend. The community intervention teams worked between 8am to 7pm daily. The out of hours team worked between 6.30pm to 8.15 am enabling time for handover between themselves and day staff. Community matrons worked Monday to Friday; 9am to 5pm; as did the single point of contact (SPA also known as the Locality Access Point LPA).

- The trust had made improvements to staffing and caseload levels since the last CQC inspection in 2015. During the last inspection we found that there were

large numbers of vacancies within the majority of community nursing teams; approximately 13% of vacant posts across community services. We found that because of the vacancies 18% of community nursing shifts were not covered and this resulted in cancelled and postponed patient visits. Trust data showed that at in March 2018, the vacancy rates across the community nursing teams had reduced to 5%.

- Throughout this inspection, we saw some teams were fully staffed; whereas others were not. However, managers and staff consistently told us that nurse vacancies were quickly recruited into; and that vacant shifts were covered. Cover came from either other staff within different teams making up the shortfall; or using regular bank staff when needed.

- Data from the trust confirmed what we saw on inspection; as of March 2018 we found that 16 teams were either fully staffed or had more staff in post than was budgeted for. We saw 13 teams had staffing numbers below what was budgeted for at that time. However; we found that for most of these teams, plans were in place to recruit for vacant positions; and shortfalls were covered by other teams who had staff over their headcount.

- Despite this we saw that the out of hours teams were understaffed. The North Staffordshire team had 3.39 full time equivalent vacancies out of 27.92 required staff (24.53 were in post in March 2018); although we saw that three members of staff had left recently in February and March 2018. We also saw the sickness levels were high in this team; 12.5% as of March 2018. The out of hours team in South Staffordshire had 5.58 full time vacancies (23.37 full time equivalent staff in post compared to 28.95 which was what the trust had budgeted for). This team had two staff members leave within the previous three months; however, had a much lower rate of sickness; 4.4%. Overall, this meant the vacancy rate for the trust wide out of hours team was 16% as of March 2018. Furthermore, three patients told us they struggled to get through via telephone to the out of hours team on occasion.

- Where teams were not fully staffed; weekly meetings were held between team leaders and more senior

Are services safe?

management to ensure patients could be safely cared for. A trust escalation policy for assessing and managing safe staffing levels was in place and used. Please see the 'well led' section for further details.

- Information provided by the trust identified bank staff were used and occasional agency staff were used within community nursing. Team leaders told us their own staff worked additional hours to cover shifts when required.

- The single point of access team (SPA, also known as Locality Access Point; LAP) took calls for each community nursing team. They took new referrals and requests from current patients, GPs and carers on behalf of district nurses, the community interventions team, community matrons and therapy staff. The SPA team was comprised of mostly administrative grade staff; however was designed to have a trained nurse also in order to triage more complex referrals and requests for support. We found that although a trained nurse was allocated to some SPA teams; they would also leave the base to undertake visits to patients. When this happened, a trained member of staff would be given an 'on call' phone which they took on visits and were expected to respond to. We saw this significantly impacted upon staff's ability to undertake visits in a timely fashion due to interruptions. New clinical staff had been placed into some SPA teams at the time of inspection and were undertaking training.

- The SPA team worked office hours. During out of hours, an answering machine service took messages and could be checked regularly by the out of hours staff for urgent calls. In addition; the answer message provided an on-call phone number for patients or carers to ring direct if they required urgent assistance.

- Handovers between day staff and out of hours staff was conducted via a shared computer system; staff input patient details and visit information to be completed which was reviewed by the oncoming team. This information could be printed out and attached to patient records. Any urgent handover information was also communicated verbally; a member of staff was always on the rota to breach the gap between day staff ending and out of hours staff starting shifts.

- We saw district nursing teams also held a team handover daily; the teams would aim to return to base for a set time to discuss patients care, treatment,

changes and any risks? and any new safety messages. These meetings were chaired by a band 6 nurse (a senior staff nurse) and attendance and a basic overview was recorded.

- Team leaders and senior staff nurses had access to individual staff caseloads and to an overall case load management tool. The specific case management tool used enabled a standardised approach to district nurses case load allocation; and had been nominated for a Health Service Journal (2018) award at the time of our inspection. Caseloads were reviewed by team leaders quarterly; and by band 6 nurses on a daily basis.

- The trust employed associate practitioners within specific teams. These were healthcare assistant grades who were undergoing an associate practitioner course to support with nursing duties.

- During the previous CQC inspection we found that not all teams had administrative support. This required that community nurses needed to complete administrative tasks and frequently worked over their contracted hours. The teams we visited had administrative support available which freed availability of community nurses to undertake other duties.

Managing anticipated risks

- Staff told us about plans for managing anticipated risks to delivering the community nursing service. For example; poor weather conditions including heavy snow within 2018 prior to the inspection. All staff we spoke with were aware of management plans, which included contacting staff with appropriate vehicles; exploring where staff lived to create a patient visit plan and attending to patients' in pairs to ensure safety when outdoors and driving in poor conditions. Team leaders at each base were required to submit a local plan on each occasion of poor weather to illustrate how they would meet the needs of patients and keep them safe during these times.

- The trust had a lone working policy in place. However this recommended that local lone working systems were devised. Procedures to keep staff safe included use of electronic diaries and a 'buddy' system to monitor when staff arrived at and left appointments. Some staff had identified code words they could use if they felt threatened.

Are services safe?

- All of the community staff we spoke with in the south were aware of these procedures and told us they used them and they were effective. Staff knew what action to take if a potential risk to a colleague was identified. However; we were not assured that all staff would be aware such as bank staff; or staff returning from absence if they had not been updated as to the local procedure.

- Community nursing staff mostly worked alone. Staff told us if potential risks were identified there was an opportunity for staff to work in pairs.

- Some community teams told us that informal buddy arrangements such as texting colleagues were in place to check that staff had safety completed their duties. All staff had mobile phones but the mobile signal was variable in some rural locations and they were not always contactable.

- The major incident plan for the trust was in date and accessible for staff to access. We saw this plan covered a range of situations which could affect the service, including adverse weather and IT failure.

Are services effective?

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

Summary

At our last inspection we rated this domain as requires improvement. This was primarily because:

- Staff did not always have the time needed to undertake training and participate in supervision and competency checks.
- Staff awareness of the Mental Capacity Act 2005 was variable and the trust had not ensured that staff were fully aware of their responsibilities under that legislation.

During this inspection we found that improvements had been made. We have rated effective as good because:

- Patients received care that met best practice guidelines.
- Staff were competent and had improved training and development opportunities to provide the care that patients required.
- There was a multidisciplinary collaborative approach to care and treatment to ensure that patients received coordinated care and treatment.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005.

Detailed findings

Evidence based care and treatment

- We saw that the trust had a range of policies based on national good practice and followed national clinical guidelines.
- We observed that when administering care and treatment the use of pathways and guidance was followed. Staff we spoke with understood how National Institute for Health and Care Excellence (NICE) guidance was applied and supported local guidelines for example the prevention and identification of pressure damage to patients skin.
- We saw information that showed that various audits were undertaken to ensure compliance to National Institute for Health and Care Excellence (NICE)

guidelines. These included audits on processes around the completion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms, patients' consent to treatment and end of life care.
- We saw that staff used pathways and guidance for long-term conditions such as 'Gold standard' for palliative care.
- We saw staff used a nationally recognised pressure ulcer risk assessment tool, the 'Walsall score', to identify patients at increased risk of pressure damage. The Walsall score is a tool that is tailored to the community-nursing environment. We observed staff providing care to patients and we saw they used assessment guidelines correctly.
- Patients had an identified and clear plan of care. Although there was a need for timely review of their plan of care for three patients whose care had changed.
- The trust had undertaken ongoing audits of patients records with teams emailed to complete an audit of five patients records on a random basis. The results were reported in an annual report for 2016/ 2017. The report identified performance of all community teams and identified good practice and areas for improvement and recommendations for future practice.

Pain relief

- Patients told us they received effective pain relief.
- We saw that staff completed pain assessments were completed and they discussed pain management with patients to ascertain their pain levels and to provide advice and appropriate management.
- During the inspection, we observed nursing staff consistently ask about patients' pain levels and record this in the patient record. The staff, where prescriptions allowed, administered (additional) medication to enable effective pain relief for patients at the end of life.
- In North Staffordshire, community nurses told us that they had a greater understanding of pain control due to training they had received from the palliative care lead nurse.

Are services effective?

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST), which is a recognised assessment tool to assess nutritional risk. We saw that a nutritional risk assessment was in place, which identified risks to the patient's dietary intake, and actions required to ensure they had enough and appropriate food intake.
- Community nurses were able to explain what actions they would take if a patient's MUST score indicated they were at risk. They were able to refer patients to dieticians for further assessment and treatment but this was not seen during our inspection.
- We saw community nurses asking patients about their fluid and nutritional intake and they provided advice about changes they could make to improve their wellbeing. For example, diet fluid intake to improve continence.

Technology and telemedicine

- During our previous inspection, community nurses told us about their frustrations and limitations of the IT system. Community managers also told us that the system was not fit for purpose as it duplicated activity with both paper and electronic records.
- During this inspection community nursing staff told us they had a trust laptop and mobile phone. Staff could access their emails and certain electronic systems via their phones remotely. Staff could use laptops whilst out on visits although staff told us that until the trust were paperless they preferred to return to the office to work on the laptop.
- Community managers told us that there were plans for community staff to be able to use their laptops remotely although major changes to the IT system had been postponed due to the imminent merger with another trust and ensure that IT systems between both trusts were compatible.
- Staff told us that they could access face-to-face training via skype therefore enabling staff to take a more flexible approach to their training needs.
- Staff could use their trust mobile phones to capture photos of tissue damage to send directly to the tissue viability team; therefore enabling a quicker assessment and treatment plan, this was used in line with trust policy.
- Staff working in West Staffordshire told us that patients who were able were encouraged to make use of a

service called an automated texting service. This service enabled them to take monitor and take responsibility for their own health and when needed receiving information or guidance from community nurses at home. Staff gave us examples of where this had been successfully used; for example to encourage patients to take their own blood pressure readings; therefore freeing up staff to attend to patients who were not able to provide independent care for themselves.

Patient outcomes

- The trust had taken part in the National Audit of Intermediate Care service user questionnaire for home based and enablement service. The audit identified that 91% of patients had either maintained or improved their level of independence during their episode of care.
- Staff told that the trust had very recently started to capture other outcome data about tissue damage; such as whether wound healing was occurring within NICE guideline recommended timelines; such as 21 weeks for a venous wound. This project was in its infancy at the time of the inspection, so no results were available.
- Staff showed us a newly introduced audit to measure patients' who experienced wounds and tissue damage quality of life as the wound had been treated and healed. The tissue viability team had initiated the audit, which was short set of questions to be asked weekly in order to monitor patient outcomes in a different way. As this was a new way of capturing patient outcomes, no data was available at the time of inspection.
- Community nursing staff in Rugeley told us they were piloting a new initiative for wound dressings initiative that enabled community nurses to access wound dressings as part of the trust formulary at the Sandy Lane base. Community nurses told us that they were able to access wound dressings in a timely manner as they did not have to wait for a prescription or the patient or their relatives to collect it and inform them they had the dressings. They told us they felt because of more timely treatment wounds had healed more quickly but no audit had been undertaken to confirm this at the time of our inspection.
- The trust had a Commissioning for Quality and Innovation (CQUIN) for the assessment of wounds, relating to wounds that have not healed within four weeks. The audit undertaken in July 2017 was identified as a baseline for future improvement The findings were

Are services effective?

that 99% of patients (176 patients) had a wound assessment, of which 89% of patients (160 patients) had a wound assessment completed on their first visit. 94% of patients (165 patients) had data documented for all five domains which demonstrated the trust's existing wound assessment document covered the breadth of information required within the minimum dataset. Further improvements to the wound assessments have been identified by the trust as part of their continuous quality improvement.

Competent staff

- Managers told us that new staff had at least four weeks supernumerary to familiarise themselves with the patients and GP practices and feel confident in their work as a community nurse supernumerary and check their competency. All new staff also had a probationary period to check their suitability for six months.
- We spoke with one community nurse who had been in post a year they confirmed that they had been supernumerary for four weeks and felt supported by other staff.
- Staff in the community nursing teams we visited had formal and recorded supervision (one to one meetings which included how they are and any additional support needs they had) with their team leader or band 6 regularly which was recorded.
- During our last inspection, not all staff had regular clinical supervision. Clinical supervision is a requirement for continued registration to maintain safe and effective practice.
- During this inspection, staff in Stafford in addition to supervision had clinical supervision although this varied within the trust. Staff in the Stafford teams that they had clinical supervision when needed by the band 7 clinical lead. Managers told us they could identify staff to work alongside the clinical lead to support them.
- Staff at Sandy lane told us that clinical supervision was available and a band 6 nurse would usually undertake this. We saw staff working in the South had formal clinical supervision and discussed individual cases and best practice during staff handovers.
- Staff said Clinical Practice Educators (CPE) provided support and clinical supervision for community nurses when requested. This was in addition to supporting the community nurse specialist practitioner students.

Information provided by the trust showed there were seven CPEs within the Trust; one per geographical area (Moorlands, Newcastle, Stoke, Tamworth & Lichfield, Stafford, Cannock and Seisdon)

- Staff told us that they received on updates and changes to national best practice, including NICE guidelines, via link nurses (nurses with an additional role such as infection prevention or tissue viability) and attended specific meetings, training events and updates. Link nurses were also involved in relevant audits and data collection projects. For example, diabetes link nurses took part in measuring outcomes for patients with this condition, completed audits, and explained the resulting information with colleagues.
- Community managers told us that staff were encouraged as part of their development to undertake a mentorship course. When community nurses completed the mentorship course, they were able to support both student nurses and other community nurses.
- Band 6 development posts were across the majority of teams. These roles were temporary for two years, during which time staff were expected to apply and undertake the Community Specialist Practitioner course. When they had completed the course, the trust made their band 6 role permanent. Information provided by the trust identified there were 37 band 6 development posts.
- The trust provided information that there 480 community nurses working within the trust, of which were 118 nurses had a community nurses' qualification.
- We saw the trust had supported 17 community nurses to undertake the Community Specialist Practitioner degree during 2018/2018. The trust provided information that they had requested funding for 20 places in 2018/2019 and were waiting for this to be confirmed.
- Information provided by the trust identified there were 185 nurse prescribers within the trust. This meant that nurses were able to timely prescribe dressings and limited medicines for patients in accordance to their needs.
- The trust supported health care support workers to undertake the Assistant Practitioner programme and become band 4 nurses as part of a two-year degree. Information provided by the trust identified there were 30 (27.6 whole time equivalent) assistant practitioner and there were 22 assistant practitioners in training.

Are services effective?

- We spoke with two band 4 nurses who the trust had supported to complete the programme. Their role had been extended and included compression bandaging, catheterisations and administration of insulin.
- Data provided prior to our inspection showed that on 31 March 2018 86% of community staff had completed an appraisal. The appraisal rate had increased since our previous inspection but remained below the trust target of 90%. All but one community service had met or exceeded the trust target. The North community services had achieved an average appraisal of rate of 76%.
- Staff told us that their professional development was included as part of their appraisal during which time application for courses was discussed and agreed. Managers told us that when a need for professional development was identified they would make an application for funding. Funding for courses such as the specialist practitioner course was considered for all community nursing staff trust wide.
- Competency assessment frameworks to test clinical competency in specific areas were in place. Staff told us that they were supported to do their competencies and progress and a need to review competencies were reviewed at the time of their appraisal or more frequently when required.
- We saw the trust provided staff with training to support and enhance competencies in particular skill areas relevant to the service, additional training in management of syringe drivers or leg ulcer management. Staff told us and we observed that they shared learning during staff handovers and team meetings.

Multi-disciplinary working and coordinated care pathways

- There was good collaborative working across community nursing services. We saw referrals and communication networks between community nurses, specialist nurses, social care and GPs.
- All nursing staff we spoke with highlighted the effectiveness of the multidisciplinary team (MDT) working with community adult patients. A multidisciplinary meeting was held at local GP clinics every other month and chaired by GPs; whereby complex patients were discussed in order to ensure co-ordinated care. Attendees included members of the community nursing teams and community intervention teams, tissue viability staff and social services representatives. Minutes from these meetings were kept within GP practices; therefore, we did not have access to this data during the inspection.
- The community nursing teams consisted of large teams with smaller 'micro' teams within. The micro team had a band 6 nurse who led the 'micro' team and was the named nurse for the GP practice. Staff told us that this gave the GP a named person to contact and provided better continuity of patient care with the same group of nurses usually visiting the patient.
- Several of the community nursing teams were combined health and social care teams, which included social workers, physiotherapists and occupational therapists. Other teams within the South had separated from social care. Staff however told us that due to previous working relationships they had a good relationship with social workers, which benefitted patients.
- Within South Staffordshire, community nurses were aligned with social services in single teams called Integrated Local Care Teams (ILCT). Staff described effective working arrangements although not all teams were physically located within the same buildings. Staff provided examples of effective MDT to achieve positive outcomes such as enabling patients to remain in their own home. Nursing staff and social services staff could attend joint visits with patients to ensure a holistic approach to health and social care.
- Community nurses told us and we observed during our inspection they were able to access specialist teams such as the 'falls team', and tissue viability nurses who they could refer patients to when necessary.
- Staff gave examples of where community nurses and speciality teams worked well together to meet patients' with conditions such as dementia, or a diagnosed learning disability, physical health needs and mental health/ cognitive impairment needs. These examples included the successful treatment of skin tissue damage; and encouraging patients to engage with medical interventions and enabling patients to give informed consent.
- Community intervention teams working with acutely ill patients comprised of registered nurses, health care assistants, physiotherapists and occupational therapists. We observed these teams worked well in South Staffordshire to prevent unnecessary admission to hospital.

Are services effective?

- Community matrons were in some but not all areas within the trust. In North Staffordshire, we saw a community matron visiting a patient to support the management of their long-term condition and prevent admission to hospital. They told us they were part of the community team, which was 'brilliant'.
- Community nursing teams were able to access palliative care specialists both from within the trust and from local hospice services.
- We observed a community nurse contacting a pharmacist in Stafford to ensure that the patient had the correct treatment available.

Referral, transfer, discharge and transition

- Referrals to community health services came from a variety of services including GPs, practice nurses, community nurses, patients being discharged from hospital wards and complex cases in nursing homes and residential care.
- Community nurses working in Stafford and Rugeley told us that they had begun to discharge patients from their caseload more proactively. They gave examples such as patients seen three monthly to confirm actions needed to reduce the risk of skin damage due to pressure. Community nurses told us that they would explain how to reduce the risk of pressure damage and give the patient or their carer a leaflet that also explained it. They ensured they had their contact number and told them if they had any future concerns they should ring and if they needed, would visit again. Community nurses told us that a full peer review of the caseload was undertaken every three months. This ensured that they provided an appropriate and effective service for those patients who required it.
- Patients who were mobile were referred to a wound care clinic.
- Community nurses told us they were able to refer patients to other services such as, tissue viability nurse specialists, other specialist nurses such as the heart failure nurses, continence nurses and palliative care nurse. They told us they mostly received feedback from these visits and were given timely information about changes to their care and treatment.
- Community nursing teams experienced issues from hospital discharges. Staff told us that frequently referrals

were incomplete, patients were given incorrect information or there was a presumption that community nurses would have required equipment or dressings

- In Stafford and Rugeley, team leaders told us that meetings had taken place to share some of the concerns about the referral to community nursing. Staff told us they felt these meetings were positive but only included hospitals within Staffordshire. This was escalated to the senior leadership team.
- In North Staffordshire, we spoke with the community nurses discharge liaison nurses. They worked with the local hospital in relation to patient discharge and referral to community nursing. Overall patients were discharged successfully with community nurses having relevant information about their needs.

Access to information

- Staff had access to patient information held within the trust. The majority of patient records were paper based; however, some staff updated patient records on a computerised system. We saw that trust staff were able to access both sets of records to gain a full picture of patients' care needs.
- The trust used generic demographic and assessment form packs, which were transferable between teams; therefore reducing the need to duplicate information should a patient move to a different community nursing team.
- We saw, where patients' had consented to share information, nursing staff were able to liaise with GPs and other community professionals outside of the trust such as hospices, in order to share information and provide updates.
- We saw policies and guidance was available on the trust's intranet and was readily accessible to staff. We saw that staff also carried some guidelines and staff told us that they could also contact other senior staff for advice when required.
- In North Staffordshire, we saw that community nurses had regular meetings to discuss best practice such as the Clinical Champions monthly meeting. We saw that information from these meeting was shared with staff by email, during handovers and team meetings.
- Staff we spoke with in North Staffordshire told us Service to Service (S to S) electronic information was shared

Are services effective?

between the hospital and the community meaning community nurses had access to information about patients requiring nursing care who were being discharged.

- Although social services and community nursing teams were closely linked within South Staffordshire, social services used their own IT systems. However, named individuals within the trust had access to this system therefore enabling good information sharing across specialities.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw staff obtained patients' verbal consent before they delivered the care and they recorded this within the patient's records.
- The trust had undertaken regular audits (last undertaken in November 2017 and previously three monthly) of patient records and included consent within community services. All adult nursing services and the Community Intervention service had achieved 100% compliance with ascertaining and recording patient consent.
- During our last inspection, we found mixed understanding about requirements of community staff with the Mental Capacity Act 2005. During this inspection, we found that all staff we spoke with understood their responsibilities and a need to identify and record patient capacity. We heard staff discussing patient's refusal or noncompliance with care although they had capacity to understand the risks of not undertaking recommended care and treatment.

- The trust told us that training on the Mental Capacity Act 2005 was mandatory for all front line staff who have a care management responsibility, every three years. Information provided by the trust identified that 94% of community staff had received training in the Mental Capacity Act 2005 against a trust target of 90%.
- The trust had undertaken three monthly audits of the use of the Mental Capacity Act within community teams. The last available audit (November 2017) identified improvement had been made with six out of seven questions achieving over 96%. One question identified consistently low results, 'Was it documented that the decision on capacity can be delayed until the persons capacity improves?' The trust had identified to explore responses to the question and whether a 'yes' 'no' or not applicable' response was required.
- At the time our last inspection, the trust did not have a Mental Capacity Act policy. The trust sent us the Mental Capacity Act policy dated February 2016 identified for review in January 2018. Information we saw confirmed it the trust had reviewed it but final ratification had been postponed for six months with the imminent merger with another trust.
- We saw that do not attempt cardiopulmonary resuscitation (DNACPR) forms had been appropriately completed. A registered doctor completed these and we saw these forms recorded the consent of the patients' and their carers.

Are services caring?

Good ●

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

Summary

- The caring domain remains the same since our previous inspection. We have rated caring as good because:
- People were supported and treated with dignity and respect and they were involved as partners in their care. Staff provided people and their families/carers with emotional support and promoted self-care and independence where possible
- Feedback from people who used community nursing services was positive about the way they had been treated by staff.
- We observed caring and compassionate interactions between patients and we saw that staff were consistently respectful and kind.

Detailed findings

Compassionate care

- We accompanied community nursing staff on 27 home visits to patients. In every case we saw compassionate and empathetic care being provided and patients were treated with dignity and respect.
- Feedback from people who used the service and those who were close to them was positive about the way staff treated them. Comments we heard patients and their relatives share with the staff included; "Your care and compassion is very much appreciated" and, "Thank you for caring and looking after my [relative]". One patient who could not verbally communicate their thoughts about their care gave us the thumbs up when we asked if the community nurses were caring.
- We observed that staff did not hurry patients when they provided care and treatment. Staff gave people the time they needed. We visited one patient who was unable to communicate verbally. We saw that the nurse did not hurry the patient whilst they used their communicate aid to communicate.
- Staff worked consistently with patients in a caring way which protected patient dignity. We saw staff covered patients as much as possible when administering care; and were gentle and caring in their approach.

- The trust had implemented a six C's challenge award based on the nationally recognised six C's for health and social care. These six C's included; care, compassion, competence, communication, courage and commitment. Trust data showed that one community nursing team had achieved this award to date.
- The trust used the Family and Friends Test as a means of receiving patient and family feedback. The trust data for April 2017 – March 2018 showed that 99% of 7515 patients in the North and 98% of 8638 patients in the South would recommend services run by the trust to their friends and family. This exceeded the national target of 90%.

Understanding and involvement of patients and those close to them

- People told us and we saw that they were involved and encouraged to be partners in their care and in making decisions, with the support they needed. Plans of care centred on what the patient wanted. Staff asked patients if they had any questions, and treatment plans were summarised to ensure the patient understood. One person and their husband told us, "All the nurses have been brilliant and they all explain things".
- We saw that staff took time to listen to patients' concerns and explained care plans using clear, simple language to make sure patients understood what was going to happen. Staff involved family members and carers where appropriate; and provided appropriate information for continued care.
- Although patients did not necessarily see the same nurse on every visit, it was clear from our observations, patient records and conversations between staff and patients/relatives/carers that the staff made an effort to get to know the patients. Staff engaged in conversation; demonstrating knowledge and understanding of the patients' relevant medical needs, and also the patients' personal preferences. This was done in a professional way which showed interest and involvement with patients and relatives/ carers.

Are services caring?

- Staff provided support and guidance to patients' and carers in order to enable them to support self-care. For example, staff supported people to acquire the skills needed to monitor and manage their diabetic needs if this was appropriate.

- Staff working within the single point of access (SPA, also known as locality access points) referral call centres were polite, open and friendly and clearly explained any instructions or messages to the patients and/or relatives/carers. We saw that staff provided appropriate information to patients; and returned calls to pass on additional messages. Call handling staff gave examples of where they had supported patients over the phone. For example, if a patient was struggling to speak due to breathing difficulties associated with their illness; staff could access patient details and reassure the patient that they did not have to talk too much whilst on the phone.

Emotional support

- All staff we spoke with told us that part of their job was to provide emotional support not just to patients but also their families and carers. We observed community nursing staff giving holistic care including support for close relatives. Staff demonstrated a good knowledge of people and their unique situations and provided tailored emotional support.

- Staff were respectful of patients' wishes. Although they offered emotional and practical support; staff did not press this when a patient or relative/carer had declined. Where patients chose to accept support; community nurses promptly and efficiently organised this.

- We saw staff engage and communicate in a way that enabled patients and relatives/carers to gain reassurance. Staff allowed extra time where necessary and when possible to provide additional emotional support. This included staff working within SPA referral call centres who would ensure they had given enough time to support the patient prior to leaving the call. Staff within the SPA team told us that when possible, they would continue to chat to patients who they knew to be lonely and isolated in order to provide support; despite the main reason for the patients' call to be dealt with.

- We saw that when patients or relatives/carers rang the SPA in an agitated or emotional state; staff spoke calmly and enabled the caller to explain their point of view whilst listening. This aided the de-escalation of difficult conversations.

- Where appropriate, patients and their relatives/carers were given details for support groups.

- Staff told us that following the death of a patient, they were able to make an additional visit to relatives/carers in order to offer bereavement support and to signpost to appropriate support agencies.

- We saw all members of community nursing teams could refer patients to the community psychiatric nurse for support with mental health symptoms.

- Where appropriate patients were enabled to manage their own health and care when they can, and to maximise and maintain independence.

Are services responsive to people's needs?

Good 🟢

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

Summary

At our last inspection, this domain was rated as requires improvement. This was because:

- The trust was not effectively monitoring how staff were responding to urgent and routine appointments.
- Appointments were also often moved or cancelled frequently as demand outweighed capacity.

At this inspection, we found improvements had been made and we have rated responsive as good because:

- People received personalised care that was responsive to their needs.' Services were planned and delivered to meet the needs of people receiving community nursing care. The trust had recruited more community nurses and nursing assistants. This meant there was enough staff to respond to patients' needs.
- The skills and experiences of nurses and the skill mix of teams were good and meant that complex needs of patients could be responded to effectively. Care and treatment was coordinated with other services and providers. Nurses worked collaboratively with other professionals and with each other within other teams to ensure patients received care and treatment in a timely way.
- Nurses responded well when patients' needs changed and reacted quickly to ensure patients received the right care at the right time.
- People received continuity of care and this was beneficial for patients care and recovery in their own homes.
- Peoples' concerns and complaints were listened to and used to improve the quality of care. Complaints were managed in accordance with the trusts' complaints procedure and staff learning took place where applicable.
- The trust took part in local and national audits and, where identified, action plans were in place to make improvements

Detailed findings

Planning and delivering services that meet people's needs

- The trust and staff in clinical teams were aware of people's complex health needs and services were well coordinated to meet those needs.
- Staff told us that arrangements for services were identified by commissioners and were dependent on the needs of patients. For example in the South they did not have community matrons but had specialist nurses for long term conditions. Whereas in the North there were community matrons in place.
- There were large community nursing teams with 'micro' teams that were aligned to GP practices to provide continuity of patient care.

- When the needs of people changed, staff took action to address this. For example, at a weekend previous to our inspection the staff cover had been severely depleted so a community nurse had organised a meeting every Friday to discuss the staffing needs for the weekend. The meeting included the nursing sisters from each of the three areas. This meant that weekend workloads could be split evenly between the three teams. This worked well and the three teams also helped each other where they could.
- Different teams we spoke with had different ways of managing 'outliers'. These were patients that either had GPs in Staffordshire but lived in a different county; or patients that lived in Staffordshire but were registered with an out of county GP. Some teams were willing to visit both sets of patients, despite not being commissioned to see those who had GPs out of county. Other teams saw the patients who they were commissioned to care for. All teams we spoke with told us how they communicated with community nursing teams within different trusts to resolve any concerns regarding patient care and treatment.
- There was an eight weekly Integrated Care team meeting where patients with complex care needs were discussed.

- The trust and staff in clinical teams were aware of people's complex health needs and services were well coordinated to meet those needs.

Are services responsive to people's needs?

Good ●

- Staff told us that arrangements for services were identified by commissioners and were dependent on the needs of patients.
- There were large community nursing teams with 'micro' teams that were aligned to GP practices to provide continuity of patient care.
- The trust took part in the National Audit of Intermediate Care and Home Based services. When compared against the national mean, this appeared in the best performing trusts (461trusts participated) for response times. National mean time from referral to assessment is 5.8 days. Intermediate care North and South report less than a day, and are one of the 13 home based services that report none of their patients wait over 2 days for a service
- The greatest difference between the North and South based Intermediate care services were found in the average duration of service.
- The national average was 31 days and median 27 days. The North was showing as below the median line at around 18 days, whilst the South was showing a slightly longer length of stay on the service at around 33 days.
- The national picture reflected that 72% of patients remained within their own home with support and after receiving community nursing care and treatment.

Equality and diversity

- Staff confirmed translation services were available for people whose first language was not English and were able to provide examples where the interpreter service had been used.
- Leaflets and other written communication could be offered in large print and be translated into other languages where required.
- One staff member told us they were able to access interpreters if needed, but would use family members sometimes if they were there but told us it was not normally acceptable.
- There was an Equality and Diversity policy in place for staff to refer to and staff received training in Equality, Diversity and Equal Rights every three years. Training for community nursing staff was above the 90% trust's target for both the north and the south.

Meeting the needs of people in vulnerable circumstances

- Staff met the needs of patients in vulnerable circumstances. Staff could tell us how they did this for

patients with dementia care needs through involvement of their family members. A staff member told us about a patient who had a learning disability and how staff understood his needs and went 'over and above' their role to help him eat his meals. Although the district nurses were there to give nursing treatment, as part of their visits they also took the time to show carers how to assist the patient eat his meals safely.
- Staff visited patients in vulnerable circumstances and worked well as a team to ensure their patient's needs were met. For example a nurse told us how the team visited a patient living in very poor home environment with complex needs and refusing care. The nurse explained how integrated care meant that nurses were able to speak directly with social workers and therapists. This resulted in more care input being funded, a safeguarding referral was made and 'Home First' were able to assist.
- Data sourced from the trust showed that in 2016 the trust enabled specialist assessments for patients who had hearing or visual difficulties. This was done by enabling a number of staff to attend a specific course which allowed them to undertake these assessments.
- Staff we spoke with understood how certain members of the population may find it more difficult to access the trusts' services; such as homeless patients, or patients who are not registered with a GP. Staff told us such cases, although rare within the trust, would be assessed on an individual basis.
- We saw good evidence of patients being offered choices about care and treatment and staff actively sought best options to work around patients' daily lives while balancing safe methods for best health outcomes.
- We observed community staff providing care and treatment for people with a learning disability. We saw that staff explained what they were doing in plain English and asked the person if they understood.
- We observed staff treat a patient with a learning disability in a clinic. Staff told us that the patient preferred to come to the clinic as their house was unsuitable. Staff told us they were able to support the patient and wash their legs before the dressings which the person was unable to do in their own home until they had a shower fitted. Staff demonstrated a good awareness and understanding of patients with

Are services responsive to people's needs?

dementia or learning disabilities. Staff were able to refer to specific teams within the trust for additional support such as the learning disability crisis team; therefore ensuring patients with additional needs were supported

Access to the right care at the right time

- The community nursing services provided care seven days per week twenty four hours a day. During our previous inspection we found that there were some gaps in service provision such as between 8am and 9am and between 5pm and 7pm. Staff confirmed that there were no gaps in their service and at least one community nurse was on duty at all times.
- We asked community nurses about their performance for urgent visits. They told us that their agreed performance indicator (KPI) was within 24 hours for new urgent referrals. They told us and in Stafford the Neighbourhood manager showed us information that confirmed this was met. Community nurses told us and we saw during our inspection that urgent visits such as a blocked catheter or pain management would be undertaken within two hours.
- Community nurses worked to help ensure patients accessed the right treatment at the right time, for example we noted, on a visit to a patient, that the patient had experienced oedema in both feet, and, with the consent of the patient; the nurse had spoken with the GP and had arranged a review of the patient's medication. A change in medication had helped alleviate the oedema in the patient's feet.
- Daily care was planned around meeting patients' individual needs and nurses listened and responded to what patients wanted. For example daily visits were carried out to support patients requiring complex stoma care.
- Staff were very responsive to patients' needs offering holistic care and the staff told us the trust has embraced this. Patients had holistic assessments where all activities of their daily living were assessed and recorded in their care plan.
- We saw that staff asked patients about what times were most convenient for them. For example one patient said that their clinic appointments had been arranged either on their day off or on their way to work.
- We observed in patients' records there were contact numbers for the community nursing service including the out of hour's service.

- We saw that community nurses encouraged patients to provide self-care where appropriate; such as either the patient or a carer taking monthly blood pressure readings, or administering insulin injections.
- We saw nurses taught a relative how to apply bandages to the patient's legs overseen by a weekly visit by the nurse. Nurses said the emphasis was on handing care back over to the patient and giving them back their independence wherever possible.
- Patients who could be supported to travel were encouraged to attend ambulatory clinics such as leg ulcer clinics, therefore ensuring more patients could be seen in a timelier manner. The trust supported patients and their families suffering with diabetes to self-care by giving them training in how to manage their diabetes and medication.
- At Leek Moorlands there was a Priority 1(P1) nurse on duty Monday-Friday. The P1 took new calls and assessed them. This ensured urgent visits were seen as a priority leaving the other community nurses in the team to continue with the visits on their caseloads.
- When there was no registered nurse on site at community nursing bases to triage calls and referrals within the Locality Access Point (LAP); a team made up of primarily administrative staff to take and co-ordinate patient/ professional requests and referrals) a member of staff, in some teams, was given a mobile phone to carry round on patient visits to provide an 'on call' service. We observed that this directly impacted upon staffs' ability to attend patient visits as they were regularly interrupted by phone calls and messages. This was discussed with staff and team leaders; plans were in place for permanent clinical team members to be present in the LAP room in order to take a triage calls. In some areas; cover was provided by other clinical staff within the building therefore there was no impact to patients.
- Staff and patients within the Stafford area told us about their difficulties when they rang the LAP. They told us that there was no answerphone facility which meant that the phone would ring out unanswered and then cut off. Staff told us that as this LAP was so busy staff would be unable to pick up answerphone messages. One patient told us about their frustration trying to ring them when they needed advice about a change to their treatment. This was escalated to the senior management team who were working on addressing the issue

Are services responsive to people's needs?

- Staff worked well to reallocate less urgent patients should they be required to attend an urgent referral or request. However, we saw on occasion that highly skilled staff were delivering care that could have been delivered by health care assistants. Therefore, this impacted upon the more skilled staffs' ability to attend more complex cases. We were told of initial plans to consider recruiting lower grade staff in order to manage less complex patients; to reduce this problem.

- Staff were monitored to ensure they spent appropriate amounts of time with patients to deliver the anticipated care. However, staff were able to be flexible to adapt the time needed where required. Patients at the end of their life were allocated extra time per visit.

- During our previous inspection staff told us that they were frequently unable to complete all their visits and meant that visits were frequently cancelled, postponed or passed to the next shift (sometimes being passed back again to the following shift) due to the workload. During this inspection staff told us and we saw that only in exceptional circumstances were visits cancelled or postponed and if this did happen they completed an incident form so the reasons could be investigated.

Learning from complaints and concerns

- The Complaints Policy was displayed within the offices and staff were aware of how to follow this and patients had a copy at their home.

- We were given an example of a recent formal complaint and how this was resolved locally through open discussions with the patient. The complaint was regarding staff attitude; however upon further exploration it became apparent that the advice given to the patient had been misconstrued.

- Staff told us that any complaints and identified learning was shared both within handovers and team meetings.

- Team leaders told us that when a complaint was made about the team they were notified. Team leaders and managers told us that they addressed informal concerns and complaints quickly and involved the Patient Advisory and Liaison Service (PALS) and shared learning within the team. Formal complaints were investigated by an independent person who had not been involved in the patients care. The trust had received a total of 33 formal complaints for Community Nursing between March 2017 and March 2018. Two had been received relating to anticipatory medicines and staff had been learning to ensure that medicines remained appropriate and this had been actioned and shared more widely within the trust. There was a district nurse clinical expert in place to help with complaint investigations

Are services well-led?

Good ●

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

At our last inspection, this domain was rated as inadequate. This was because:

- Effective systems were not in place to ensure that the safety and quality of care was consistently assessed, monitored and managed to improve patient care.
- Staff told us they felt overworked and reported a culture of fear and anxiety about the safety of the service.

At this inspection, we found that significant improvements had been made and we rated well-led as good because:

- Suitable leadership structures were in place to provide staff with the support and guidance they required. Staff described their team leaders and managers as approachable and accessible.
- Staff shared and followed the trusts values, vision and strategy to promote patient centred, high quality care.
- Effective systems were in place to ensure that patient safety and the quality of care was consistently assessed, monitored and managed to ensure safe and effective care was delivered.
- We found a positive shift in staff culture. Staff felt able to report safety concerns and felt empowered to make innovative changes to the way they worked to improve patient care and staff morale.

Detailed findings

Leadership of this service

- At our previous inspection in 2015, we found there were inconsistencies with effective leadership across adult community services. At this inspection, we found significant improvements had been to the leadership of this service.
- We found that staff were kept updated about changes relating to the future of the trust. All the staff we spoke with were aware of the planned merger of the trust by another local NHS trust. Staff told us they received regular communication about this and had been offered the opportunity to meet with CEO to discuss future plans.

- Each team or service had a team leader who provided day-to-day operational leadership. The team leads were managed by neighbourhood managers who were in turn managed by area managers. All the staff we spoke with told us that managers were approachable, accessible and supportive.

- Team leaders and managers told us they were supported and challenged by their line managers to ensure they were promoting a culture of safe quality care. Team leaders and managers told us this 'challenge' came through regular risk and quality meetings and forums.

- Managers accessed training to enable them to acquire and maintain their leadership skills. A leadership training program was in place to ensure any potential and/or new managers were supported to acquire the necessary leadership skills. Data from the trust showed that 212 staff members accessed this training between 1 March 2017 and 28 February 2018. Managers also told us they could 'top up' their management skills by attending masterclasses and leadership learning bites sessions. Trust data also showed these trainings were also well attended with 161 staff attending masterclasses and 147 staff attending leadership learning bites between 1 March 2017 and 28 February 2018.

- Band 6 nurses (senior staff nurses) were encouraged to attend management meetings with team leaders in order to develop and progress.

- Managers told us they empowered junior staff to think creatively and challenge ways of working to improve patient care. We saw that junior staff were empowered to do this as many examples of this were shared with us. For example, a band 6 nurse in the North of the county had highlighted a need to review planned weekend visits and staff cover across all teams in their area in preparation for each weekend. The nurse had been empowered to set up Friday meetings where a band 6 nurse from each of the three teams met to review the

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staffing and workload for the weekend. Visits were shared equally across the teams which meant that no team was left with reduced capacity. This was in its infancy but staff told us it had worked well.

Service vision and strategy

- At our previous inspection, we found that the trusts values were not widely shared and staff felt there was no clear strategy due to a high number of staff reconfigurations and service redesigns. At this inspection, we found significant improvements had been made and staff were aware of understood the service's vision, values and strategy.

- The staff and managers we spoke with were able to articulate the service's vision and values with 'providing high quality care' being the priority cited by the majority of staff. Staff also told us the visionary slogan for the move towards the new trust which was 'Better together'.

- We saw the trust vision and values were displayed on the desk top of staffs' computers; serving as a continual reminder.

- Senior managers from the trust had been working alongside the senior managers from the trust that was set to merge with them. This was to agree new ways of managing services and to ensure that any changes to how services were managed would be in the best interests of local patients and staff.

- The Trust developed it's quality priorities through a consultation process with service user representatives, staff, and partner agencies between February and April 2017. These set out the trusts overarching priorities for quality improvement for 2017-18. These priorities focussed on; safety, experience and effectiveness. The trust regularly reviewed their progress towards achieving their agreed priorities and data sent from the trust showed they were on track to do this.

- Through the sustainability and transformation partnerships the trust had engaged with other local NHS and government organisations to plan and improve how local health and social care needs could be met. Senior managers spoke about how they could influence and improve how care was delivered locally through this engagement work.

- Staff worked with people to promote independence, reduce social isolation and enable them to manage their own long term health conditions. For example,

ambulatory wound care clinics had been introduced in the county to encourage people who were able to receive care and support in their local community to do so. This promoted independence and reduced social isolation.

Governance, risk management and quality measurement

- At our last inspection, we found that effective governance systems were not in place to ensure that the quality of care was consistently assessed, monitored and managed to improve patient safety and their care experience. At this inspection, we found significant improvements had been made and effective systems were now in place to assess, monitor and improve patient care.

- A quality assurance system had been implemented by the trust. This involved each nursing team receiving a quality assurance visits based around CQC's key lines of enquiry. Data from the trust showed that at the time of the inspection 27 community nursing teams had received a quality assurance visit. Completed visit reports showed that these visits highlighted areas that teams were performing well against and also identified areas where more support was needed. Action plans showed that where support was required, this was planned for. For example, a quality assurance visit to Wombourne Clinic in December 2017 identified that staff were not always following the trusts handover procedure. We saw that action had been taken to address this as we observed staff following the trusts handover procedure during our inspection and handover records confirmed the team consistently used this new procedure.

- Audit cycles were in place that ensured there was continuous assessment and monitoring of quality. This included; pain assessment audits, DNACPR audits and record keeping audits. When audits had identified areas for improvement, action plans were in place, followed and reviewed to ensure positive steps were taken towards making improvements.

- The trust had effective systems for identifying and mitigating risks. Risks within services were recorded on registers and were discussed in detail on a monthly basis. At the time of our inspection there were three open risks on the risk register that related to community

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nursing. All three open risks had plans in place to mitigate any potential impact of the risk to patients. The risk register also showed these risks were reviewed on a regular basis. Staff were aware of significant risks within their services and knew what was being done to address them. For example, two of the open risks related to staffing vacancies. Staff reported that the trust took timely action to advertise and recruit to clinical posts in order to mitigate the risks associated with staffing vacancies. Managers confirmed that clinical post vacancies were signed off in a prompt manner and some new approaches to recruitment had taken place, such as; one stop recruitment events had taken place. These events enabled potential staff to apply and be interviewed for clinical posts on the same day. Data sent to us from the trust showed that adult community nursing vacancies had decreased over the past 12 months with vacancy rates reducing from 7.1% in March 2017 to 4.8% in February 2018. Trust data also showed that the trust was now regularly over recruiting each month as planned vacancies were being recruited to in a proactive manner.

- Neighbourhood managers received a monthly risk report on all incidents that had been reported in their teams, which allowed them to maintain an awareness of risks and to identify any trends that may have occurred. We reviewed the incident reports for adult community nursing dated December 2017 to February 2018 which confirmed that these reports contained information on numbers and types of incidents reported each month together with trends, and a breakdown of incidents by locations and teams.

- We saw that systems were in place to ensure lessons were learnt from incidents and near misses. Shared learning was disseminated across all community nursing teams via the monthly incident reports which contained detailed trust wide information about how future incidents could be prevented. Staff we spoke with confirmed this information was shared with them.

- Team leaders attended monthly 'accountability' meetings with area managers. During these meetings a variety of topics were discussed which included mandatory training compliance, vacancies and sickness,

local risks to the service, incidents and complaints. We saw meeting minutes for March 2018 which confirmed these areas had been covered. These minutes were fed back to staff through team meetings.

- The trust had a business interruption plan which included arrangements for staff to support patients in extreme cold and snow. The plan identified levels of risk with level four being the highest. The plan included agreed arrangements to hire four-wheel-drive vehicles to enable staff to visit and check vulnerable patients. Staff confirmed during the recent heavy snow there was one four wheel drive vehicle that was used to access the villages where there had been deep snow drifts, they also used volunteers with four wheel drive vehicles and some staff also walked to nearby calls.

Culture within the service

- At our last inspection, staff told us they felt overworked and reported a culture of fear and anxiety about the safety of the service. At this inspection we found a significant positive shift in the culture within this service.

- A positive patient focussed culture was embedded from the trust board right down to the staff who worked on the ground floor. Senior managers whose jobs were at risk due to the impending merger remained positively focussed on patient care stating they could, 'see the benefits for patients' and they, 'wanted the best care for patients'.

- Staff provided examples where they had been supported back to work in a caring manner following a period of absence. Likewise some staff were also able to give us examples of how managers had worked with them in a supportive and caring manner in response to adverse incidents that triggered any development needs.

- Staff demonstrated a positive attitude towards team work and they told us they were proud of their work supporting patients in the community. Staff described a supportive environment in which team members were aware of each other's strengths and skills.

- Staff at Greyfriars had designed and used a 'pledge tree' where each leaf showed what they had pledged to do through their work for their patients and colleagues.

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Examples of pledges included; 'I will admit my shortfalls', 'I will consider the feelings of my colleagues' and, 'I will voice my concerns'. This showed that the staff culture at this service was supportive and caring.

- Staff told us they were able to raise concerns about safety and quality through a number of channels. This included speaking directly with line mangers and senior managers or speaking to a speak up guardian. Some staff gave us examples of how raising concerns had led to improvements in patient care and staff morale as managers had been responsive to these concerns. For example, staff in Tamworth told us they had previously expressed concerns that continence assessment visits were frequently rescheduled as these were not deemed as urgent care needs. Staff recognised continence issues had a major impact on people's health and wellbeing and as a result of raising concerns a dedicated continence nurse was introduced to the team, ensuring these needs were being assessed and managed promptly.

- A lone working policy was in place to promote staff safety. However, we found some teams were not always working in accordance with this policy. For example, a staff member we spoke with in one of the South teams knew there was an agreed safety word for their team to use, but they did not know what this was. This placed them and their colleagues at potential risk of harm.

- Staff told us they had been through many changes since our last inspection. This included the implementation of new IT systems, new ways of working and the planned merger. The majority of staff reported feeling informed and accepting of these changes.

Public engagement

- The trust sent us data to show they regularly sought and acted upon patient feedback. Each team had to send out a set number of feedback forms per month and the results of these were then analysed. Any negative feedback was acted upon where possible. Trust data showed that between April 2017 and March 2018 114 suggestions had been made by patients in relation to the delivery of community services operated by the trust. These suggestions had been themed into three areas which included; communication, change of process (appointments) and recruitment. We saw that learning actions had been created in response to these

suggestions for improvement. For example, in response to suggestions raised in relation to staffing of a SPA team in the south, additional staff had been recruited to the team.

- The trust had consulted with service user representative groups to agree the trusts priorities for 2017/2018. Data sent from the trust showed that service user feedback was used to make service improvements through this consultation and ongoing engagement. For example, we saw that the trusts power of attorney leaflet had been changed as a result of service user feedback.

- Where teams were less well known to the local community; such as the community intervention team within Tamworth; staff had placed posters in prominent areas such as local community centres and GP surgeries in an effort to engage with both the public who may use services; and organisations who may refer to the team.

- We saw that local partners were consulted with when service redesign was indicated. This ensured feedback from these partners was obtained and considered before making decisions about the future of services.

Staff engagement

- We found staff engagement was much improved since our previous inspection. The trust used a combination of email, intranet messages and newsletters to engage with community staff. We saw information on the trust web site informing staff about the inspection.

- Staff in all the locations we visited were aware of the trust's weekly newsletter, 'The Word', and told us they found it useful and informative.

- Staff engagement events regarding the planned merger by another local trust had been held to ensure staff had the opportunity to engage with this process. Staff told us they were asked for their input regarding the new name for the combined trust.

- Staff said they had been kept informed of the trust's community specification and strategy and they had opportunities to make suggestions at each stage.

- During our previous inspection we found that staff sickness rates across the trust were higher than the national average. At this inspection we found that there was an improvement in staff sickness rates. For example, the team leader in Rugeley told us that staff sickness in their team had greatly reduced. Trust data

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showed that cumulative staff sickness rates within Rugeley had significantly reduced from 9.80% in March 2017 to 4.59 % in March 2018. Overall between March 2017 and March 2018, the sickness rates for community adult nursing teams ranged between 5.66% and 6.17%.

- During our previous inspection, nursing staff told us that the merger of health and social care had been challenging because teams only had one manager each, and if that manager was from a social work background they were not familiar with community nursing. During this inspection managers told us that in response to this feedback, there had been a change in team structure within the South community services and now nurses managed nurses which they felt was more appropriate.

- Senior managers reported disappointing staff survey results for the December 2017 survey. Some of the areas where feedback scores were noted to have significantly declined included; staff feeling unhappy with their pay, feeling undervalued and not always getting the support to access training identified through appraisals. The trust had analysed this data and were in the process of developing an action plan to address areas of concern.

Innovation, improvement and sustainability

- At our previous inspection, we were not confident that innovation and improvement were actively encouraged and supported by managers. At this inspection staff in all teams shared multiple examples of how they had been encouraged to think creatively and innovatively to improve patient care.

- The trust designed and developed a District Nurse Caseload Review Tool that was launched in February 2017. This tool has created standardised approach to reviewing district nurse caseloads. The tool ensured that all district nursing caseloads were managed and ran efficiently and effectively. The tool was awarded first prize and praised for its innovative approach at the Queen's Nursing Institute Annual Conference in October 2017 and had been shortlisted for a 2018 Health Service Journal Values Award.

- Staff told us they felt empowered to find local solutions to local problems. This had led to some innovative work within local teams. An example of a local solution to a local problem included; a nursing team at Rugeley who worked with their local CCG to set up a wound care store that enabled them to access appropriate wound care

resources without waiting for GP's to prescribe and pharmacies to dispense. Data sent from the trust showed that over 50% of patients had previously had to wait five days or longer to receive the dressings they needed for their specific wound care needs. Staff reported having a stocked wound care store had resulted in improvements to wound healing times as patients had been able to access the dressings required in a more timely manner.

- Nursing teams in the North of the county had requested and implemented a priority nurse role into their teams. This nurse would not carry a pre-planned caseload which freed them up to complete any urgent visits that were required. Staff from the Newcastle team told us this new way of working started in January this year and had meant less pre-planned visits being rescheduled as this new way of working ensured capacity was available to carry out urgent visits when required. Data from the trust relating to this Newcastle team showed that the number of rescheduled visits had dropped from 66 in January to 49 in February following the implementation of this new way of working.

- Staff working in the Stafford teams had a band 7 clinical lead. The clinical lead for Greyfriars told us that their role had been developed as a quality initiative to support quality care. All the staff we spoke in the Stafford teams with were positive about this role. The team leader in Rugeley told us they felt that the band 7 clinical lead role was an excellent initiative and they would welcome having a similar post in Rugeley.

- Staff told us that innovative ways of working were shared between teams so that other teams could choose to adopt new ways of working if this met their local needs. For example, two area managers we spoke with told us they wanted to implement the wound care stores in their areas as they saw the benefits of this for patients, staff and GP's.

- Wellbeing cafes had been set up in conjunction with local councils within South Staffordshire. These had run for six months at the time of the inspection; and were scheduled for a further six months. These cafes provided education and support to patients with long term conditions enabling them to remain independent and

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managed within community services for longer. Staff had worked with voluntary agencies to assist patients to access transport services to enable them to attend ambulatory clinics where appropriate.

- The Tissue Viability Nursing team had devised an interactive snakes and ladders game that was used as a learning tool to help staff improve their knowledge and understanding within this specialist area.

- Staff told us that integrated working where nurses, social workers and therapists shared an open office and worked side by side worked well. This meant that knowledge about patients could be shared in order to meet their care in a holistic way and that patients received the right care in a timely way. Some staff however, told us that social care staff had moved out of shared offices. Despite this they told us their relationships with social care would continue to be maintained as links had been made.

- As part of a development course a band 5 nurse working in the North of the county (junior nurse) had created a spreadsheet to monitor patient journeys of patients with palliative care needs. This helped to inform the Gold Standard Framework meetings of patient experiences.