Salford Royal NHS Foundation Trust

RM3

Community health services for adults

Quality Report

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Date of inspection visit: 13, 14 and 15 January 2015
Date of publication: 27/03/2015

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

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

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

Summary of findings

Ratings

Overall rating for community health services for adults	Outstanding ☆
Are community health services for adults safe?	Good ●
Are community health services for adults effective?	Good ●
Are community health services for adults caring?	Outstanding ☆
Are community health services for adults responsive?	Good ●
Are community health services for adults well-led?	Outstanding ☆

Summary of findings

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Overall summary

We visited a sample of Community Adult Services on 13/14th January 2014. We held two focus groups with a range of staff who worked within the service. We talked with about 35 people who use services (including 13 telephone interviews) and four carers. We spoke with six managers, and about 20 registered and four unregistered staff. We observed how people were being cared for in clinics and in their own homes and reviewed care or treatment records of people who use services.

We judged that Community Adult Services were outstanding. This was because we found that there arrangements to ensure that patients were safe, and that there were systems to report, investigate and learn from safety incidents and near-misses. We found that care and treatment was based on current guidance and best practice and there were arrangements to monitor the standards of care. Patients told us that they were treated with kindness and empathy and that their dignity was upheld. Services were arranged to respond to patients' individual needs and could be accessed when they were required. We found that services were well-led, with a positive culture with a clear vision, values and strategy which staff were engaged in and identified with. There were robust governance systems that ensured information flowed freely between the various levels of management, including the executive team and front-line staff.

Summary of findings

Background to the service

Community Adult Services in Salford are provided by Salford Royal NHS Foundation Trust, a combined acute and community trust. The majority of Adult Community Services formed part of the Division of Salford Health Care and were managed by the Intermediate Care Directorate. Community Dentistry and Renal Services were managed by other divisions which integrated acute and community services.

Community Adult Services in Salford included:

- Bladder and Bowel Services
- Community Rehabilitation and Falls services
- Community Nursing, including out-of-hours services and clinics
- Rapid Response team
- Supported Discharge team
- Tissue Viability team
- Community Dental services
- Satellite haemo-dialysis units.

Services were provided in patients' homes or in one of three "Gateways" at Eccles, Walkden and Pendleton and at a variety of health centres and medical centres. There were satellite haemo-dialysis facilities at Bolton and Wigan hosted by local hospitals.

Our inspection team

Our inspection team was led by:

Chair: Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission

Team Leader: Heidi Smoult, Deputy Chief Inspector of Hospitals, Care Quality Commission

The team included CQC inspectors and a variety of specialists including

Why we carried out this inspection

We carried out this inspection to complement our comprehensive inspection of the services provided by Salford Royal Hospital.

Our methodology included an unannounced visit carried out on the evening of 27 January 2015 and a public listening event. At the public listening event we heard directly from approximately 60 people about their experiences of care.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 14 and 15 January 2015. During the visit we held two focus groups with a range of staff who worked within the service, such as nurses, health care support workers and students. We talked with about 35 people who use services (including 13 telephone interviews) and four carers. We spoke with six managers,

Summary of findings

and about 20 registered and four unregistered staff. We observed how people were being cared for in clinics and their own homes and reviewed care or treatment records of people who use services.

We visited Walkden Gateway where were reviewed the general clinic, community nursing and podiatry services, Eccles Gateway where we looked at the general clinic and dental services, and Pendleton Gateway where we visited audiology and dental services. We visited Burrows House where reviewed the community rehabilitation service and the falls service. At Lower Broughton Health Centre we looked at the general clinic and community nursing, and at Sandringham House we reviewed the evening community nursing service. We visited the Salford Royal Foundation Trust satellite haemodialysis unit at Bolton General Hospital.

What people who use the provider say

- Patients and carers we spoke with were overwhelmingly positive about the care and treatment they received from Community Adult Services. Words and phrases such as "Excellent," "Fabulous," "Friendly," "Incredible," "It's a very good service," "The best in Britain," were used extensively in their feedback.
- We looked at the results of two patient surveys, the National Audit of Patient Reported Experience Measures (PREM), and the "Patient Experience Feedback – District Nursing Teams September 2014". The national audit showed results that were better than national averages. The overall feedback showed that patients felt they were treated with empathy and kindness and that their homes and belongings were treated with respect. They also felt that they were aware of the goals of their treatment and that they were involved in discussions and decisions about their care and treatment.

Good practice

Our inspection team highlighted the following areas of good practice:

- The system of daily safety huddles, and intra-team situation reports.
- The team-based audit programme and the monitoring of results and actions.
- The Community Assessment and Accreditation System, and arrangements for gathering patient feedback.
- The mandatory training and professional registration monitoring systems. .
- The system of competency assessment and associated records.
- The use of the "Butterfly Scheme" for people living with dementia.
- The arrangements for ensuring the safety and security of lone workers.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should consider arrangements for the management of patient records at Walkden Gateway.
- The provider should consider how discharge information between the acute and community sectors could be made more effective.

Salford Royal NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

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

Good

Are community health adult services safe?

By safe, we mean that people are protected from abuse

Summary

We judged that Community Adult Services achieved a good standard of safety. This was because we found that there were robust methods of reporting, investigating and learning from incidents and near-misses that were well understood by staff and were embedded in their daily work. There was a risk register that ensured potential risks were known and assessed and appropriate controls implemented. There were plans to deal with a major incident or events that would disrupt the delivery of care.

We saw that there were processes and systems that protected patients from the risk of infection, and the risks associated with equipment used in their care and treatment. Overall, there were safe systems of medicines management, although we found that systems ensuring the security of prescription pads were not clear.

There were adequate numbers of suitably qualified, skilled and experienced staff to meet people's needs and we noted that staff completed their mandatory training. It was acknowledged that a number of nursing vacancies placed some pressure on existing staff but we saw that action had been taken. This included a review of staffing numbers, an active recruitment programme and there were arrangements to ensure that any staffing shortfalls were managed on an on-going basis to minimise the impact on patients.

Records were found to be accurate, comprehensive and current and they supported the delivery of safe care. However, the mix of electronic and paper records used caused some staff frustration and carried potential for inaccuracies.

Incidents, reporting and learning

- Incidents were reported using an electronic reporting system which also provided reports for managers on reporting activity and incidents. All staff we spoke with

were aware of the system and told us they were confident in its use. Staff indicated that they felt empowered to report any safety incident or near-miss without any fear of reprisal.

- We saw that records were kept regarding all safety incidents and near misses reported in Community Adult Services. These included details of the incident and how and why it occurred. We saw that actions to mitigate against recurrence had been formulated and noted that these were appropriate to the incident described.
- We analysed the incident data for the period October 2013 – March 2014. The majority of incidents (38.8%) were related to treatment procedures, with the second highest number being related to patient accidents. It is worth noting that no incidents at all were related to infrastructure, including staffing and facilities, and the two incidents relating to implementation of care was also very low. 89% of all incidents reported were of low or no harm to the patient.
- We reviewed the root cause analysis of an incident which occurred in October 2014. We saw that there had been a thorough investigation and analysis of the incident. Learning points had been identified and actions were underway to address care issues that had been identified.
- We saw a root cause analysis that as part of its template included actions that would ensure that the service's obligations with regard to their duty of candour were met. We noted that these actions had been completed and that the patient and their family had been informed of the harm done, that an investigation was underway and that a copy of the investigation report was to be provided.
- There had been one never event reported in Community Dental Services in April 2014. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In this incident a wrong tooth was extracted by a student. We saw that following thorough investigation, the procedures used had been changed to include the supervising tutor dentist to identify that the correct tooth for extraction and to observe the procedure until completion. A check-list based on the World health Organisation "Surgical Checklist" had also been introduced. We saw that this new procedure was displayed on the clinic wall. Dental staff we spoke with were aware of this incident, of the learning points identified and the changes to procedures which had been made. This showed that there was learning from never events which resulted in action to further reduce the risk of recurrence.
- We saw the notes of team meetings and safety huddles which demonstrated that incidents, their analysis, lessons learned and practice or process changes were discussed with and communicated to staff. Staff we spoke with told us that the discussion and consideration of safety events was frequently part of their routine
- Community Adult Services participated in the National Safety Thermometer programme, a national prevalence audit which allows us to establish a baseline against which we can track improvement. Data submitted since October 2013 showed the number of catheter associated urinary tract infections was fairly steady over the period October 2013 – October 2014 with an average of 8 reported per month. The number of pressure ulcers was also steady over the same period with an average of 59.9 reported. Falls with harm have been generally low, aside from the period August 2014 and September 2014 with an average of 3.4 reported per month.

Cleanliness, infection control and hygiene

- Overall we found that Community Adult Services were compliant with the "Code of Practice on the prevention and control of infections and related guidance" issued by the Department of Health in 2010.
- Mandatory training records dated December 2014 showed that 85.89% of eligible staff working in Community Adult Services had completed mandatory Infection Prevention and Control training, below the trust target of 95%. The target had been achieved for hand hygiene training with a rate of 98.92% had completed but had not been achieved for Aseptic Non-Touch Technique with 83.88% of eligible staff completing training in (range 0-100%).
- There had been no reported cases of MRSA detected by community adult services since April 2014.

- We saw that facilities where patients were treated were clean and hygienic. We saw cleaning schedules that clearly set out how and when premises and their equipment should be cleaned.
- Patients told us that they had no concerns regarding the cleanliness of premises. One said that the clinic they attended was "Spotlessly clean."
- We observed that an officer from NHS Properties, the contracted cleaners was carrying out an audit checking against National Cleaning Standards. There were "Infection Control Audits for Primary Care Premises" carried out; we saw an audit for Higher Broughton Health Centre that was carried out in December 2014 and saw that an overall "green" rating of 93% was achieved and that a further audit in 2015 had been scheduled. This demonstrated that cleaning standards were monitored to ensure they met national specifications.
- We saw that shared equipment such as blood pressure machines, scales and trolleys was labelled with a distinctive label to indicate it had been decontaminated and was ready for use.
- We observed that clinic environments had supplies of personal protective equipment (PPE) which staff used appropriately. We also observed that staff had adequate supplies of, and used PPE when they visited patients at home.
- We saw that premises had adequate hand-washing facilities and supplies of hand sanitizer for staff and the public to use. We saw that hand hygiene compliance was audited and the results did not raise any concerns.
- We noted that disposable curtains were used and were changed at the recommended six-monthly intervals. However, at one location where we found that the change date had been exceeded by about two months.
- We reviewed the decontamination processes for dental instruments. Instruments were decontaminated off-site in a central unit. For those elements of the decontamination process were completed at the dental clinic, for the storage of sterile supplies and the maintenance of a safe water supply we noted that the requirements of the Department of Health guidance, "HTM 01-05: Decontamination in primary care dental practices" (2013) were being met.
- We found that all surgical instruments used by the Podiatry department were single use only, removing the need for decontamination and reducing the risk of infection of patients. We saw that the instruments were all stored in clean and dry conditions, in sealed packs to ensure they remained sterile.
- We saw that clinical and domestic waste was segregated and that waste bins were covered and operated by foot pedal. We observed that contaminated clinical waste awaiting collection was stored securely and safely in a locked metal store. This ensured that there could be no unauthorised access or interference with this hazardous material.
- "Sharps" waste was disposed of in appropriate receptacles which were properly labelled, although we found some isolated examples where assembly details were not completed. Overall, we found that the conditions of the "Health and Safety (Sharp Instruments in Healthcare) Regulations 2013" were being met.
- We looked at the latest results of the Community Assessment and Accreditation System appraisals for eight teams. We saw that all achieved a green rating in standard six relating to Infection Prevention and Control. As part of this assessment 14 elements of the service were assessed. Four of the assessments found one area where compliance was not reached but there was no common theme, and the breach of the standard did not affect the overall score.

Maintenance of environment and equipment

- We found there were systems to ensure that staff were trained and competent to use the equipment used in their daily work. Mandatory training records dated December 2014 showed 93.89% of staff in Community Adult Services were up-to-date with medical equipment competencies. We saw records at one unit which showed that the specific competencies for each staff member were recorded, and the dates when this competency was formally assessed and then re-assessed either by self or other assessment methods.
- We looked at records which showed that equipment was identifiable and traceable, and that service dates were recorded. We saw separate records that showed that syringe drivers were tracked and that their last and

next service dates were recorded to ensure that they were maintained in line with manufacturers' recommendations. We noted that these service dates were current.

- However, at one location we found that one item of equipment appeared not to have been registered and another was known to be two months past its due service date.
- We saw that equipment used for dental x-rays at two sites had local "local rules" outlining its safe use as required by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) and these were displayed to enable staff to reference them easily. We also saw a service certificates from an external contractor for the machines, although these were undated they was current as the next services due were recorded as June 2015. We noted that the technical quality of dental x-rays were recorded for each exposure, however the last available audit was dated April 2012, although we were told a more recent audit had been performed. This meant that the risks associated with the use of x-rays in dentistry were minimised.
- Many community based clinics operated from buildings where local authority services such as library and housing services, GP practices and health services were co-located. We found that the premises we visited were modern, spacious and well maintained. Staff described the community facilities as, "A fabulous environment," and patients told us they appreciated the quality of the care environments. The only negative feedback we received related to delays in checking in for appointments when there were queues of people using other services.

Medicines management

- We saw that medicines that needed to be stored in a 'fridge to ensure they remained in optimal condition were kept in designated 'fridges. We saw that the temperature was checked daily and that a log was maintained to record this.
- We found an instance where records relating to prescription pads used by a nurse were incomplete. While some serial numbers were being recorded (ie the first and last in the pad) the latest in the series was not. This meant that individual sheets were not traceable and could be removed by unauthorised persons. We found there was a policy for non-medical prescribing. We looked at this on the trust intranet and noted it had passed its review date of November 2014. The policy included the requirement to record the serial number of the prescription next in the series, but the mechanism for this was not specified. Therefore, we found that there was inconsistency in how this was done. We were also told that nurses take prescription pads home with them, and although they stored them securely there was a risk they could be misappropriated.
- We were shown an audit of medicines in one service which 95% compliance with the specified benchmark since September 2014.
- We looked at the latest results of the Community Assessment and Accreditation System appraisals for eight teams. We saw that all achieved a green rating for standard eight relating to medicines management. A total of 13 care elements were assessed and the compliance rate was 100% across all of these.

Safeguarding

- We saw records that showed the District Nursing Service had been subject to four safeguarding referrals in the previous six months. All related to neglect or omission of care and three of these had been substantiated.
- We saw evidence that staff were making appropriate safeguarding referrals. Staff we spoke with were aware of the trust safeguarding leads and knew how to contact them. These leads were described as being helpful and supportive in safeguarding issues,
- Mandatory training records dated December 2014 showed 89.98% of eligible staff were up-to-date with Level 1 Safeguarding Adults training. Rates for Safeguarding Children Group 1 stood at 88.88%, Group 2, 98.5% and Group 3, 50%. This shows that although staff were undergoing training in safeguarding, it was not always kept current.
- We looked at the latest results of the Community Assessment and Accreditation System appraisals for eight teams. We saw that all achieved a green rating in standard three which related to safeguarding and in which 11 key areas of knowledge and practice were assessed.

Records systems and management

- Mandatory training records dated December 2014 showed 87.65% of staff working in Community Adult services had completed up-to date mandatory training in Information Governance, below the trust target of 95%.
- We saw that when patients' confidential records were transported between sites they were place in a distinctive sealed package designed for the purpose. We found an instance where a clinic nurse was collecting notes for the next day's clinic from a base and taking them home. Although the notes were in the sealed package this did not represent adequate security in relation to confidential records.
- We saw that Community Adult Services used a mix of paper and electronic records although we were aware that developments were in train to move to a fully electronic record. There were duplicate records at patients' homes and bases, with the risk that these records may not be congruent with each other. Staff expressed some frustration at the current situation and told us it could be cumbersome and confusing, especially as all acute sector records were electronic and could only be accessed from service bases.

Mandatory training

- We reviewed the lead nurse reports to the divisional Clinical Governance and Risk Meeting dated January 2015. We noted that for community nursing services appraisal rates ranged from 81.08% - 99.48% with an average of 94.43%. For other intermediate care services the range was 88.33% - 100% with an average of 95.89%.
- Staff we spoke with told us that they were supported to attend their mandatory training by their managers and that they received reminders when it was due.
- There was system that if mandatory training was not completed this could result in a suspension of pay. There were safeguards in the systems so that when training was not available for organisational reasons, staff would not be penalised. Staff we spoke with were all aware of this system and were supportive of it. They told us that since its introduction compliance with mandatory training had improved considerably.

Lone and remote working

- We saw there were systems to ensure that the safety of staff when working in the community especially alone. Staff showed us electronic tracking and alarm systems that were being used and described how they used them to ensure their safety. The whereabouts of staff could be tracked using these devices. There was a facility for security staff to listen in to risky situations and to call for urgent help from police or other emergency services. The staff we spoke with felt these devices made the feel safe in their work. We heard stories that some staff were reluctant to use these devices, and we saw notes in team meeting minutes where this was discussed and it was made clear that failure to comply was a disciplinary matter.
- In addition we saw that teams had systems to ensure staff diaries and schedules were available to team members and managers, and that there processes where staff checked in and out of calls. For example, in the Community Rehabilitation Service we saw systems to ensure the safety of lone workers. We noted a lone worker board was displayed at the base ensuring that lone visits were known. Additionally all visits were recorded in diaries. There was a system in place where workers called to indicate the start and completion of a lone visit.
- There were systems to highlight patients who presented a risk to staff. Details of patients of concern, such as those receiving a ASBO's or being barred from trust premises, were circulated by the security team. These patients and their management were discussed in team safety meetings and we saw that these discussions had been recorded.

Assessing and responding to patient risk

- Mandatory training records dated December 2014 showed 83.37% of eligible staff in Community Adult Services were up-to-date with training in Adult Basic Life Support (range 0 -100%).
- On a satellite renal unit we saw that the National Early Warning System (NEWS) had been introduced to help identify patients at risk of deterioration, We saw that this was supported by a system (SBAR, Situation, Background, Action, Review)) that supported staff to escalate their concerns to senior colleagues in a structured and explicit way.

- We saw that each premises contained resuscitation equipment, including emergency medicines, that was appropriate for the clinical activity at that location. We saw that is was checked appropriately to ensure it was ready for immediate use.

Staffing levels and caseload

- We saw documents that showed that a comprehensive review of the capacity and demand of Community Nursing Teams was carried out in January 2014. This concluded, "In order to deliver the required levels of activity a minimum investment of 10 WTE nurses (£300k) is required". We looked at the business case that was developed to support this conclusion. In our discussions with management team we were told that this investment had been made available and that the organisation was actively recruiting community nurses. This was confirmed by community staff we spoke with.
- We also saw a capacity and demand review of the Community Rehabilitation Service and the community-based IV therapy team. This meant the service was reviewing its staffing with regard to anticipated demand to ensure there were sufficient, appropriately qualified, skilled and experienced staff to meet patients' needs.
- We looked at staffing rotas for the month of December 2014. We saw that they were constructed to ensure that there were appropriate numbers of staff at appropriate grades on duty to carry on the service. We saw that rotas had been amended in the light of unforeseen absences to ensure that the service could continue to operate safely.
- We looked at records which showed that flexible labour was used to cover shortfalls on duty rotas. From July-December 2014 we saw that Community Nursing Services used an average of 1.59 whole time equivalent (WTE) members of flexible staff per month, and that the out of hours Community Nursing team used an average of 7.56 WTE and the Rapid response team 1.95 WTE. Other Community Adult Service teams had no use of flexible labour recorded.
- There was a system for senior team to communicate a "sitrep" (situation report) each day with peers and managers. As part of this process staffing available, workload and the complexity of the caseload were discussed and where necessary staff, or patient visits were reallocated to ensure patients' needs would be met. We saw records of these reports and observed one happen. Staff confirmed that the reallocation of resources was an option that was used to maintain safe caseloads.
- When we spoke with staff, their major concern was the numbers of staff available to provide the service. They reported feeling under pressure. However, they showed an understanding of the issues and were aware of the recruitment strategies that were in use. Staff told us that they perceived the main issue to be one of retention with newly appointed staff leaving quickly. They felt this was due to new staff not fully appreciating the role of community services and pressures this could present.

Managing anticipated risks

- We found a risk register was maintained for Community Adult Services that identified current risks and rated the level of that risk. Key control measures were put in place and we saw that action plans, duly reviewed, were drawn up to obviate, or further control and manage the risks identified. We were able to test the control measures for the risk relating to syringe drivers and found that these were all in place.
- All staff throughout the service that we spoke with were aware of and could articulate the principal risks in their local work area and those facing the service overall.

Major incident awareness and training

- We were provided with copies of the "Community Nursing Business Continuity Plan" and the "Business Continuity Plan, SRF - Intermediate Care Service." We reviewed this document and found it contained all of the contingencies to be adopted by the service in the event of a major incident or business continuity event. An appendix clearly articulated the short, medium and long term risks to the service and its users and staff. We noted that these local plans were congruent with the trust's overarching "Major Incident Policy."
- Staff at a satellite renal unit were able to produce the relevant policies promptly when requested and demonstrated an awareness of the contents.
- We saw minutes of a meeting held in January 2015 to review plans and responses to the risk of a patient presenting with Ebola infection. We noted that due consideration was given to the risks likely to be encountered in Community Adult Services. We saw

copies of the Ebola action card that was produced for community healthcare workers. This meant that the organisation was anticipating and responding to and new emerging risks.

Good

Are community health adult services effective?

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

Summary

We judged that Community Adult Services achieved a good standard of effectiveness. Overall, we saw that national guidance from government, the National Institute of Health and Care Excellence and professional bodies was complied with and that staff showed awareness of relevant guidance in their work.

We found that overall quality of care was monitored through the Community Assessment and Accreditation System. We saw that the service participated in the 2013 National Intermediate Care Audit, and that each department carried out at least one clinical audit annually.

Staff were supported through face-to-face meetings with their manager and through an annual appraisal which generated a personal development plan for each individual. Staff were encouraged and supported by the organisation to gain addition qualifications relevant to their role, and staff in senior positions held appropriate qualifications. There were robust systems to ensure professional staff remained registered with the relevant professional body.

We found that patients could access all professionals relevant to their care through a system of multi-disciplinary teams and that patients' care was co-ordinated and managed.

There were systems to gain people's consent prior to care and treatment. Where patients lacked the capacity to give consent, there were arrangements to ensure that staff acted in accordance with their legal obligations.

Detailed findings

Evidence based care and treatment

- Overall, we found care complied with relevant guideline issues by the National Institute of Health and Care Excellence (NICE), government departments learned societies. We saw that staff showed awareness of relevant guidance and referred to it in their daily work, for example during a multi-disciplinary meeting at the Community Rehabilitation Service. We saw that copies of relevant documents were available at bases for staff to reference, and staff told us they could also access this via the trust's intra-net site. This was confirmed by data from the Community Assessment and Accreditation System that we reviewed.
- In Community Dental services we found guidance on the management of wisdom teeth extraction was being followed. However, we found that in 11 dental records we reviewed, no soft tissue examination results were recorded by student hygienists and therapist as recommended by General Dental Council Standards and Faculty of General Dental Practice.
- We noted that practice in the Community Rehabilitation Service complied with "Clinical guidelines for the pre and post-operative physiotherapy management of adults with lower limb amputation" issued by the British Association of Chartered Physiotherapists in Amputee Rehabilitation (BACPAR).
- We observed that the care for people at risk of falls was broadly compliant with guidance from the National Institute of Health and Care Excellence (Falls: assessment and prevention of falls in older people CG 161). We looked at a falls audit carried out by one service in December 2014 against the requirements of the National Service Framework 6. We saw that 36% had reduced their fear of falling and 60% had showed no change

Nutrition and hydration

- We looked at the latest results of the Community Assessment and Accreditation System appraisals for eight teams. We saw that all achieved a green rating in standard five which related to meeting nutritional needs. A total of 11 elements of care were assessed and there were no instances where any of these elements were not met.
- We saw that patients were assessed for risk of malnutrition using a validated, nationally recognised risk assessment, the Malnutrition Universal Screening Tool in services where this was appropriate, for example community nursing. We saw that this assessment was reviewed at appropriate intervals.

Good

Are community health adult services effective?

- We saw an example where on initial assessment a patients potential risks of malnutrition and possible dehydration were identified and actions taken to address these concerns.

Telemedicine

- We were told that Community Adult Services did not directly provide telemedicine services. However, and range of new technologies, such as movement sensors linked to an alarm for use at home, were provided by the local authority. Staff we spoke with knew of the technologies available, and how to refer patients for its use.
- We found that Community Nursing Staff were trialling the use of tablet computers. At present their use was restricted coding visits and accessing emails, although we were told of plans to extend this to the use of an electronic patient record. Some staff reported problems with Wi-fi access whist out and this was felt to lessen the benefits of the system. Staff told us that the tablet computers were loaded with applications detailing current guidance in the management of leg ulcers and the British National Formulary, which gave then access to reference materials when they required them. A new initiative was to use the cameras function to record wounds to assist in assessment and evaluation of care.

Approach to monitoring quality and people's outcomes

- Community Adult Services monitored the quality of services provided through the use of the "Community Assessment and Accreditation System". This system assessed a comprehensive range of quality indicators covering a range of quality standard domains including Governance, Person Centred Care, Safeguarding, Safety and Risk Management, Meeting Nutritional Needs, Infection Prevention and Control, Clinical Effectiveness and Management of Medicines. Assessments were performed by an assessor from outside the department on an unannounced basis. Services were awarded a Red, Amber, Green rating for each standard and overall. Sustaining a green rating for two years allowed the service to become accredited as a "Safe, Clean and Personal Every Time (SCAPE)" department. A manager told us that at the time of our visit 36 out of 48 eligible community services had been inspected using this framework.
- We found that a validated system for measuring therapy measures had recently been introduced; Therapy Outcome Measures (TOMS). However, it was too early to analyse the information to establish patterns and trends.
- The management team told us that teams within Community Adult Services were expected to carry out at least one local audit per year. For example, we saw one team had conducted an audit regarding the management of allergies in December 2014 and noted that 100% compliance was achieved. These audits were registered with the trust Quality Improvement Team. We found that the progress of these audits was monitored, that there was a system for presenting results, that relevant action plans were devised and that the progress and impact of these action plans were reviewed.
- In January 2015 one service had carried out an audit looking at BP measurement and found poor compliance with 22% of patients having their BP recorded. We saw that the reasons for this poor compliance had been explored, and changes made to ensure this occurred. There was plan to re-audit to test the efficacy of the changes made. This demonstrated a positive response to concerns highlighted by audits to improve patients' outcomes and safety.
- The Community Assessment and Accreditation System specifically assessed clinical effectiveness (standard 7) and included 11 key elements of care for assessment. We looked at the latest results for eight teams and found that each team was rated green and there were no instances were an element of practice had not met the required standard.

Competent staff

- We saw records that showed 100% of staff had attended a corporate induction programme.
- We were shown records that showed that competencies relevant to staff roles had been developed and that there were systems to ensure that competency was demonstrated and reviewed. We looked in detail at competency assessments in a satellite renal unit and noted they were comprehensive, complete and up-to-date.

Good

Are community health adult services effective?

- We reviewed the lead nurse reports to the divisional Clinical Governance and Risk Meeting dated January 2015. We noted that for community nursing services appraisal rates ranged from 65-92% with an average of 78.9%. In other intermediate care services the rates ranged from 60 – 100% with an average of 80.75%.
- Staff told us they had regular, formal meetings with their line manager which were recorded. We were shown examples of monthly one-to-one meeting between a staff member and their manager. We saw it covered a wide range of issues relating to the management and development of the service and team, updating on clinical and corporate issues, and discussions on personal performance and development.
- We saw there was a process to assure the organisation that its registered staff remained registered with relevant professional bodies. Staff and managers were advised when trust records indicated registration was due for renewal and re-registration was verified. A manager demonstrated the system to us.
- Staff told us that they were supported to gain further qualifications relevant to their role. We saw that senior community nurses held specialist qualifications, and we spoke with a number of staff who had been supported to become non-medical prescribers.
- Registered staff in the community dental service told us they were up to date with their Continuing Professional Development which was necessary for them to remain on the General Dental Council's register. They told us they felt supported by the organisation in their CPD.
- Patients we spoke with expressed confidence in the skills and competence of those caring for and treating them. A typical comment was, "The nurses know what they are doing."

Multi-disciplinary working and coordination of care pathways

- We saw examples of agreed care pathways expressed as algorithms in order to guide staff. For example we were shown the equipment ordering pathway for intermediate care which clearly set out the steps in the process that ensured patients were provided with equipment to support their care needs. We also looked at the Intermediate Care handover process which was structured to support effective communication, and the Bladder and Bowel Service algorithm that described the process for accurate assessment and supply of continence aids.
- We spoke with a patient with complex needs. They were very positive about the standard of care they had received and said that there had been, "Excellent co-ordination between the colo-rectal team and district nurses." Another patient described their care as, "Joined up."
- We attended a multi-disciplinary meeting with the Community Rehabilitation Team. The aim of the meeting was to review patients who had received community rehabilitation for at least four weeks. We saw that staff capacity was checked to ensure that the available capacity would meet the planned activity. We found the meeting was focussed on patients goals, with current goals and discharge timescales made explicit. A complex case study was also discussed as a problem solving exercise.
- We found that social care staff employed by the local authority were co-located with health professionals which facilitated a joint approach to providing holistic care that met the needs of patients and their families and carers. We observed interactions between these staff groups which enabled them to respond quickly to the needs of patients, especially when these were changing. We saw that carers' assessments were offered by health workers.
- At a satellite renal unit we saw evidence that patients with particularly complex needs were discussed at the renal department's multi-disciplinary meeting with input from a range of medical specialities, therapy and nursing and care staff to ensure that there care plans remained relevant and met their needs.

Access to information

- We saw evidence that there were email systems to alert Community Adult Services when patients on their caseload attended A&E, or other urgent care facilities at the Salford Royal Hospital.
- Staff were able to access the electronic patient records of patients, but only from their base units. This enabled them to have access to current information about hospital based care and treatment.

Good

Are community health adult services effective?

Consent and MCA

- Staff we spoke with aware of their responsibilities in relation to the Mental Capacity Act 2005 and could describe how applied it in their daily work.
- We saw examples of records of best interest meetings that had been held when patients lacked capacity to make a decision for themselves. Overall, they complied with the Code of Practice issued by the government.
- We found there were arrangements to ensure that un-befriended patients who lacked capacity were referred to an Independent Mental Capacity Advocate when serious decisions about their health and welfare needed to be made in their best interests. We reviewed a contract monitoring report with the independent organisation that provided advocates and saw that appropriate referrals were being made across the local health economy, but were unable to be explicit about the referral rates or patterns of Community Adult Services to overall performance and compliance.
- We checked three patients' dental records who were being treated by students. We found that consent forms had been signed by the patient and the treating student and their registered supervisor, although in one case the counter-signatory was missing. We made the service aware of this and they took appropriate action.
- We saw that in patients' records consent to the care proposed was recorded. We also saw that there was a note that indicated that verbal consent was obtained before episode of care. We spoke to a podiatrist how was clear about when they needed to gain written consent prior to a procedure.

Outstanding ☆

Are community health adult services caring?

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

Summary

We judged that Community Adult Services showed outstanding standards of caring. This was because patients and carers we spoke with were overwhelmingly positive about their experience of care and treatment, and that feedback gathered by the organisation showed high levels of satisfaction. Patients said they felt treated with dignity and respect, and that they were involved in the planning and delivery of care to the extent they wished to be.

Detailed findings

Compassionate care

- Patients and carers we spoke with were overwhelmingly positive about the care and treatment they received from Community Adult Services. Words and phrases such as "Excellent," "Fabulous," "Friendly," "Incredible," "It's a very good service," "The best in Britain," were used extensively in their feedback.
- In the "Patient Experience Feedback – District Nursing Teams" dated September 2014, 100% of patients said that when visited at home staff were respectful of the patient's home and belongings.
- In the same audit, 98% felt they were treated with kindness and empathy with 94% saying they definitely were.
- We reviewed data from the "Friends and Family Test" for the period July – September 2014 for 12 Community Adult Services Teams. The average score for people who responded that they would be likely to recommend the service was 86% with a range of 64%-100%. The trust average was 94%.
- The Community Assessment and Accreditation Assessment System (CAAS) included an appraisal of standard two which related to patient centred care. A total of 16 care elements were assessed including, "Dignity and modesty is maintained by health care professionals when delivering care". "Patients are called by their preferred name and this is documented" and "Staff treat patients and relatives courteously." We reviewed eight assessments and found that seven teams achieved a green rating, the remaining team an amber one. This team had not attained the standard for two elements that related to the provision of relevant leaflets for patients.

Dignity and respect

- In the same 2014 audit, 98.14% of patients felt they were treated with dignity and respect during their appointment. 100% of patients said that when visited at home, staff were respectful of their home and belongings
- We attended two clinics. We observed that privacy and dignity were well managed with the use of curtains, and private rooms with doors locked when required.
- We accompanied staff on five home visits and observed that staff were respectful of patients' homes, and that matters of dignity were given due consideration.
- In the CASS audits we reviewed we noted that the standard for addressing patients by their preferred title was not met within two teams

Patient understanding and involvement

- We saw minutes of the "Long Term Conditions Commissioning Group" and noted it included a patient representative.
- In the latest National Audit of Patient Reported Experience Measures (PREM), 94.12% of patients reported that they had been all the necessary information about their condition or illness from the referrer. This was better than the national average of 83.66%.
- In the PREM audit, 100% of patients said they were aware of what treatment was aiming to achieve;100% said they were always involved in setting those aims, both of which were better than the national average. 75% reported that they were definitely involved in discussions and decisions about their care, support and treatment as they wanted to be; this was slightly below the national average of 80%25% said they were involved in discussions to some extent with none reporting they were not at all. This was better than the national average.

Outstanding ☆

Are community health adult services caring?

- In the "Patient Experience Feedback – District Nursing Teams" dated September 2014, 93.75% of patients definitely felt involved as much as they wanted to be in decisions about care and treatment, and 100% felt there was the right amount of involvement by carers or family members. 100% felt the treating healthcare professional gave them enough information about their care and treatment.

Emotional support

- In the "Patient Experience Feedback – District Nursing Teams" dated September 2014, 96.3% of patients felt supported during their appointment or visit.
- We saw that patients in the Community Rehabilitation Service all had a named worker who responsible for co-ordinating their care. This was confirmed by the Community Assessment and Accreditation System data we reviewed.

Promotion of self-care

- In our discussions with staff, patients and carers we found that there was an appropriate rehabilitation focus and that patients were encouraged to be partners in their care planning and enabled to participate in care activities.
- At a satellite renal unit we saw that there were targets agreed as part of the Commissioning for Quality and Innovation (CQUIN) process with local commissioners relating to shared care. With patients becoming more active involved in delivering their treatment. Although the target had not yet been reached we saw that the unit was working with patients who had volunteered for the scheme to assist them to achieve self-care.

Good

Are community health adult services responsive to people's needs?

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

Summary

We judged that Community Adult Services provided services that responded to patients' individual needs. This was because we found there was a focus of providing services close to where people lived and at times that were convenient to them. There was provision to ensure that essential services were available out-of-hours. There were no major issues with waiting lists, although we found examples where some teams were not meeting their local response targets.

We found that consideration was given to needs of people living with dementia, those with complex needs and patients for whom English was not their first language. Feedback from patients was encouraged and actively sought. Complaints were investigated and responded to, staff made aware of the issues raised by complaints and where appropriate changes made as a result.

Detailed findings

Service planning and delivery to meet the needs of different people

- We found that Community Adult Services employed a range of advanced nurse practitioners to ensure people with specific conditions received expert care. These included those for Heart Failure, Diabetes and Cardiac Rehabilitation.
- We saw tracking records that demonstrated that patients assessed as high risk of pressure damage, or who had such damage, were provided with appropriate pressure relieving mattresses to meet their needs. These records also showed that hospital style beds were supplied to patients when their condition and care needs warranted this.
- We saw records that detailed the expenditure on interpreting services from July to December 2014. We could see that interpreting services had been provided throughout this period to Community Nursing, Tissue Viability, Bowel and Bladder Service, IV Services, and Intermediate Care Rehabilitation. Staff we spoke with were aware of the need to obtain interpreting services when required and could describe the process for doing so. We saw an example of a sheet that enable staff to identify which language was being used when they could not ascertain this in any other way. This meant that patients whose command of English was insufficient to ensure they could communicate their needs, symptoms and experience were supported.
- We saw that Community Dental Services operated a drop-in clinic for people who were homeless and therefore unable to access mainstream dental services.
- We saw that patients with dementia were identified to staff through the use of a discreet butterfly symbol so that they would be aware of their special needs. We saw these symbols in use on patients' notes and on whiteboards in offices. Staff we spoke with were aware of the significance of the butterfly symbols and could discuss with us how they might approach communicating and managing the care of people living with dementia and their carers.
- We saw that people living with dementia had care passports outlining their care needs and preferences, and other information important to them and that these were used to inform care and to ensure key information was passed on when the patient used other health and social care services.
- We observed that staff were aware of patients' needs in relation to adequate pain control and that this was assessed. For example, at a clinic we watched the nurse ensuring the patient had had pain relief and was comfortable before commencing a potentially painful procedure.
- We saw that services were provided in modern, well-designed and maintained premises. There was full disabled access with lifts, ramps and disabled toilet facilities all present. Elements of dementia friendly design, such as colour contrasting sanitary ware fittings, were used. Signage was clear and directed patients to appropriate areas.
- Premises contained adequate waiting facilities with comfortable chairs and patients could access to drink and other refreshments.

Good

Are community health adult services responsive to people's needs?

- We saw that there were displays and leaflets covering condition-specific topics, general health advice and signposting to local health and social care services.

Access to the right care at the right time

- In the latest National Audit of Patient Reported Experience Measures (PREM), 94.28% of respondents felt the length of time they had to wait for my care from the community team to start was reasonable. This was in line with the national average.
- Patients and carers we spoke with told us that they did not experience difficulty getting care and treatment when they needed it. One described the service as, "Very accessible." Another said, "It's an excellent service, no waiting, quick appointments the next day, rapid prescriptions."
- Community Nursing Services were available at all times. There was a separate out-of-hours teams. There were six teams providing services 'till mid-night' and then one team for the remainder of the night that was aligned with the GP out of hours service. This meant patients could access care at any time, and they, or other health and social care professional could contact the community nursing service at any time if required.
- We observed a nurse working with a patient to ensure their appointment times fitted in with their shift work. However, we received some negative feedback about the lack of clinic opening at weekends, which meant patients who would normally attend a clinic were dependent on the weekend service. One patient pointed out this was difficult for patients like themselves who had weekend jobs as the visits were perceived as, "Unreliable, turn up at all hours."
- We spoke with podiatry staff who told us that extended hours clinics were held on Saturdays and some evenings to enable people with work or other commitments to attend when it was convenient for them. We were told that the Community Rehabilitation Team had operated seven days a week, but had reverted to five services as patients said they did not want to be seen at weekends.
- In PREM audit 76.47% of patients said appointment or visit times were always convenient for them in line with the national average.
- In the "Patient Experience Feedback – District Nursing Teams" dated September 2014, 88% of patients said that if they needed to see someone at short-notice it could usually be arranged.
- In the same audit, 85.71% of patients reported they were seen on time (or early) at their appointment, and the remainder were seen within 15 minutes. This meant that appointment times were not delayed and clinics ran on time.
- Patients we spoke with told us that clinics ran on time, or that services visited when they expected. A patient said, "They come on time, and 'phone is they are going to be late."
- Staff we spoke with told us that visits were rarely cancelled as they were able to pass on any uncompleted work to the evening or out-of-hours teams. Patients did not tell us that missed or late calls was a frequent occurrence. We saw data that demonstrated that a small number of visits were cancelled on the day for Community Adult Services but considered that as the reporting period was for the financial year 2013 -14, this was not sufficiently current.
- We found that the rapid response team average response to referral was less than one hour for the period April - November 2014 against a target of four hours. However, the community rehab team did not meet their response targets. Average response times for community rehabilitation were 30.2 days, more than double the target of 14 days, and 10.3 days for the early supported discharge service against a target of seven days.

Discharge, referral and transition arrangements

- In the latest National Audit of Patient Reported Experience Measures (PREM), 70.59% of patients definitely felt involved in decisions about when care from the community team was going to stop, and 88.34% definitely felt they were given enough notice of when the service would stop. This was better than the national averages of 63.27% and 68.57%.
- In the same audit, 81.25% (national average 71.34%) of respondents reported that staff discussed further health care services required when they were discharged from the service.

Good

Are community health adult services responsive to people's needs?

- We observed an assessment visit of a patient new to a Community Adult Service. We saw the referral and assessments documents were completed and that an appropriate onward referral was made as a result of the assessment. This showed that staff were aware of other services and how to access them.
- In the period April – November 2014 100% of referrals to the IV Therapy team were accepted, and 98% of those to the Rapid Response Service. This indicates that the referral criteria for these services were well understood by others in the local health economy.
- We found that the respiratory nursing and physiotherapy teams worked with patients with long term conditions such as TB, lung cancer or Chronic Obstructive Airways Disease whilst they were in-patients at the hospital, and followed them through on discharge ensuring continuity and consistency of care.
- Staff working in Community Adult Services told us that the quality of referral data had deteriorated, both internally from the trust and from neighbouring hospitals. We were given examples including, inaccurate referral and discharge dates or incorrect clinical information such as referral for a dressing change when the patient required insulin administration. We went on two visits of new patients and found that the reason for referral was not accurate. In one case referral to rapid response team was necessary and in the other and found that the patient needed injections, not the requested skin tissue viability assessment. The need for anti-coagulation injections did not appear on the referral data and caused additional input from the nurses and potentially delayed the patient's treatment.

Complaints handling and learning from feedback

- We looked at the three complaints received for the years from 2013 and 2014 that related to the Community Dental service. We saw that these complaints had been investigated and the outcomes had been communicated to the complainant via a letter from a senior member of the management team. In these cases the complaints were not substantiated.
- We saw internal audit data from eight teams which showed the standard "Information regarding the Patient Advice and Liaison Service and how to contact them is displayed in a prominent area or staff hand out leaflets to patients," was met within seven teams. We saw literature on how to feedback concerns or complaints displayed in health premises.

Outstanding ☆

Are community health adult services well-led?

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

Summary

Overall, we judged that Community Adult Services were well-led. This was because there was a clear vision and values that were shared by staff and demonstrated in their work. There was a clear articulation of the strategic direction for the service and staff felt engaged with this. Consideration was given to ensure that developments were sustainable.

There were systems to ensure good governance and monitoring of standards and performance. There was an effective escalation and cascading of information from the board to front-line workers, and vice-versa.

We found that there was a positive culture, with staff and managers feeling proud of their work and achievements and speaking well of their colleagues and the organisation. Front-line staff felt supported by their managers to deliver high quality care, and empowered to implement and participate in quality improvement projects. Managers, including those at executive level, were described as being visible, open and approachable. However, community based staff felt that the organisation was focussed on acute services and there was a lack of appreciation of the contribution community services made and the challenges they faced.

Detailed findings

Vision and strategy for this service

- We found that staff could clearly articulate the vision and goals of the trust and their service. We had discussions with staff where they explained, with examples, of how they found consideration of the trust values had helped them to approach their daily work and to address specific problems. However, reference the "Sally Standards" and "Always Events" concepts were not raised by staff during our discussions.
- We looked at the Draft Annual Plan Objective 2014/5 for the division responsible for the majority of Community Adult Services. We saw that they were aligned to the trust overall objectives and set out the projects and issues which the management team would focus on in the coming year. We noted that long-term objectives to be achieved over the next five years were also incorporated into these plans. We also looked at plans for individual services, for example Community Nursing, and again could see alignment with trust and divisional objectives. This showed that there was consensus on the organisation priorities and an appreciation of how these needed to be implemented at each level of the organisation.
- We looked at the plans for an Administration Review in the Intermediate Care Services. We saw that an option appraisal had been carried out, and that when the preferred option was established a detailed project plan was devised, with appropriate time-scales that would allow the project to proceed in a controlled and managed way. We saw that the implementation of this plan was monitored and reviewed. This demonstrated that development projects within the service were considered in the context of the overall service strategy and its implementation.
- We looked at the "Operational Procedure–Integrated Care Programme (ICP) Multi-Disciplinary Groups (MDGs) & Care Coordination" dated December 2014. We noted it contained a concise, but clear vision for integrated care in the locality, as well as an overview of the essential elements of the integration and a description of the operational arrangements to enable the vision to be realised.
- We reviewed documents form Salford Clinical Commissioning Group concerning "Long Term Conditions; Local Commissioned Services". We saw that these showed how Community Adult Services were engaged in developing strategic plans for the period April 2015 – March 2020. We noted the strategy was comprehensive and set out objectives and outcome measures that would bring health benefits to patients living with a range of long-term conditions, and made explicit the way in which these objectives would be achieved. This meant that the service was engaged with partner organisations in furthering the strategic objectives of the local health economy.

Outstanding ☆

Are community health adult services well-led?

- All staff we spoke with were aware of the strategic plans and direction of the service, especially the integration agenda. They told us they felt engaged with the developments that were proposed or in train.

Governance, risk management and quality measurement

- We found there was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff. We spoke with a wide range of staff who were familiar with the service's governance structures and felt confident regarding its effectiveness. We reviewed the minutes of various governance meetings and found they contained information on incidents, complaints and other critical incidents, the outcome of audit activity and progress against action plans and the review of risk registers. We noted that there were systems for formally signing off action plans or removing risks from the register which ensured that matters were managed appropriately to their conclusion.
- Staff told us about the system of safety huddles and we saw these in operation. These were daily meetings where all relevant safety information was shared with the teams. These were supplemented by team leader safety huddles held weekly and we reviewed the formal notes kept of these. Staff told us they found the huddles invaluable about keeping up-to-date with local and organisational safety issues and valued these meetings as a source of valuable feedback and the opportunity to escalate issues.
- There were systems for gathering patient feedback and we saw the results of surveys, for example the Friends and Family Test.
- The Community Assessment and Accreditation System had been implemented as a robust system for assessing the overall quality of care with Community Adult Services. This system specifically reviews governance arrangements at a local level and looks at 16 elements of care. We reviewed the latest results of eight teams and found that six achieved a green rating and two an amber one. We saw that three teams failed to meet the standard relating to notes and records, and two did not have a local governance plan of which staff were aware.
- At a renal satellite unit we found there was no current, agreed service level agreement (SLA) with the host organisation. We saw that an agreement had been formulated in 2011 but this appeared not have been formally ratified. We saw evidence that this SLA was being reviewed by all partners at the time of our visit.

Leadership of this service

- Some staff told us that they felt the executive 'walk-arounds' were developing, and some reported having seen board members in the last few months. The assistant director was described as being visible more so than the executive team. Staff appreciated that this senior member was accessible and approachable.
- On staff member summed up their thoughts as, "Good team, good line managers."
- Band five and six staff could access an in-house leadership programme that was accredited by Salford University.

Culture within this service

- Staff we spoke with spoke positively of the organisation, their teams and their work. The phrase "Proud to work here," was commonly used. One staff member said, "Staff have good values and are committed", and another described the trust as "Proactive, responsive."
- However we reviewed the Friends and Family Test data for 12 teams and found that in answer to the staff item "How likely are you to recommend this organisation to friends and family as a place to work?" 63% (range 36% - 100%) said they would do so. The trust average was 74%.
- Part of the organisational approach to quality improvement is the use of the Plan, Do, Study, Act methodology. We found that all staff we spoke with were familiar with this model and discussed the process as they applied and the "tests of change" in which they were involved. This showed that staff were engaged with the organisational approach to quality improvement.
- There was a consensus of opinion amongst staff working in Community Adult Services that they were sub-ordinate to those working in the acute sector. One staff member said "We are the poor, relation, an afterthought". They gave the example that training for basic life support was provided at the hospital rather

than in community settings. Another member of the same team commented, "We feel forgotten; I appreciate the logistics but we are more isolated." Another staff member told us "The acute sector don't quite get what the community do."

- Staff in another team told us they felt like poor relations and that the organisation was very acute service centred with a very acute, medical focus. As an example they said that new policies did not always address issues relating to community based practice, or did not apply at all. However, the staff felt that this was improving. There was a general feeling expressed that there needed to be a more equal relationship between acute and community services in the organisation.

Public and staff engagement

- We saw records of events and meetings which showed Community Adult Services were participating in initiatives such as the Citizen's Reference Group and Dementia Champions Group which had the aim of engaging local communities in the development of and provision of integrated health and social care services.
- We saw that the service participated in public events such as one in October 2014 to promote and celebrate National Older People's Day.
- We were told that the Bowel and Bladder Service had been renamed by patients as they found references to continence or incontinence in the service name uncomfortable. This showed that the views of patients were considered.
- We saw that teams held regular team meetings and we reviewed the minutes of these. These were in addition to daily safety huddles. This meant there were opportunities for staff to meet formally to discuss issues pertinent to the operation and development of their service.
- One particular service was identified as having undergone a period of instability and low morale. We saw the results of a staff survey that had been instigated as a result of these concerns. We noted that the report was considerate of the issues raised by staff and that action and monitoring plans were formulated to address the issues of team and management culture and relationships that were raised. This was communicated to staff in a "you said, we did" format. This showed that when problems were identified staff were involved and engaged in the process of investigating and understanding the issues and in making improvements.

Innovation, improvement and sustainability

- We saw that cost improvement programmes (CIP's) were monitored to ensure the projected savings were delivered. We noted that all the service's CIP's were risk rated as delivering the required savings in the financial year.
- At a satellite renal unit we saw that the ward team had completed the Department of Health "Productive Ward Programme" in 2014 to improve efficiency and release time to care and had reported some improvements. We noted that there were concrete plans to re-visit the modules in 2015 to drive improvements further which demonstrated a culture of continuous improvement.