County Durham and Darlington NHS Foundation Trust

RXP

Community health services for adults

Quality Report

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Date of inspection visit: 3-6 February 2015
Date of publication: 29/09/2015

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)
RXP83	Dr Piper House		DL3 6JL
RXP11	Shotley Bridge Community Hospital		DH8 0NB
RXPCC	Chester-le-Street Community Hospital		DH3 3AT

This report describes our judgement of the quality of care provided within this core service by County Durham and Darlington 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 County Durham and Darlington NHS Foundation Trust and these are brought together to inform our overall judgement of County Durham and Darlington NHS Foundation 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

Summary of findings

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Summary of findings

Overall summary

Overall, we rated community health services for adults as good. We found there was a robust reporting system in place and staff felt able to report incidents and raise concerns in a 'no blame' culture. Equipment was well maintained and fit for purpose. Staff adhered to good infection control practices and we saw that medicines were stored and administered safely.

Electronic records were complete. We saw that staff used care planning and care pathways to effectively manage patients' health needs. There was positive multidisciplinary working across and between services and different professionals, which provided good, effective outcomes for patients.

We did not identify any long standing staff vacancies and we were confident that staff were trained in safeguarding, the Mental Capacity Act and deprivation of liberty safeguards.

We saw numerous examples of compassionate care and patients' dignity and privacy being respected. All the patients and carers we spoke to told us they valued the service and found the staff excellent. Patients and their carers received emotional support from staff during visits.

Patients were treated in their own homes or clinics and services were provided to prevent hospital admissions. We saw that patients were supported when they were moving between services and we observed positive inter-professional relationships. We found that complaints were addressed at the lowest possible level, but, when identified, lessons were learnt and disseminated effectively throughout the service.

All staff were aware of the vision and strategy for the trust and their service and could relate their roles in achieving this. Governance and quality measures were embedded in the service. Audits were widely used to monitor quality and receive patient feedback. Leadership within the service was strong and visible and staff demonstrated a clear respect for local leaders. The culture within the service was positive and all the staff we spoke with spoke highly of their teams and line managers.

Summary of findings

Background to the service

One of the largest hospital and community healthcare providers in the NHS, County Durham and Darlington NHS Foundation Trust serves around 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside. Services included health and wellbeing services, community-based services, and acute and planned hospital services.

Community services provided a comprehensive range of nursing and therapy services including district nursing, specialist nurses for conditions such as diabetes and palliative care, joint therapy and nursing teams such as the integrated short intervention service (ISIS), plus physiotherapy, occupational therapy, speech and language therapy and podiatry.

Nationally Darlington is ranked 75, and Durham 62 out of 326 local authorities which means there are high deprivation levels within these areas. County Durham has high levels of health deprivation with 71% of the population classed by the Department of Health as being within the most deprived group nationally. Deaths from smoking and early deaths from cancer, heart disease and stroke are all higher than the England average.

During this inspection we spoke with 24 patients, undertook 14 home visits and observed a leg ulcer clinic with staff. We also spoke with 77 members of staff, either individually or as part of two focus groups.

Our inspection team

Our inspection team was led by:

Chair: Iqbal Singh, Consultant Physician in Medicine for Older People.

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: doctors, nurses, therapists, a health visitor, district nurses, community matrons, a GP and Experts by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme.

How we carried out this inspection

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

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

Before visiting we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service-specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well-led. We carried out an announced visit from 3 to 6 February 2015.

We held listening events on 26 January and 2 February 2015 in Darlington and Durham to hear people's views about care and treatment received at the hospitals. We

Summary of findings

used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

What people who use the provider say

Patients we spoke with were very positive about the care and treatment they received.

We reviewed the feedback received from patients, this feedback consistently scored the service excellent or good.

County Durham and Darlington NHS Foundation 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

There was a robust reporting system in place and staff felt able to report incidents and raise concerns in a 'no blame' culture. Incidents were reported through an electronic reporting system. Equipment was well maintained and fit for purpose. Staff adhered to good infection control practices and we saw that medicines were stored and administered safely.

Electronic records, which included appropriate risk assessments, were completed. We did not identify any long-standing staff vacancies and we were confident that staff were trained in safeguarding, the Mental Capacity Act and deprivation of liberty safeguards.

District nursing case loads varied across the teams, however, staff told us that there were usually sufficient staff to care for the number of patients they had as part of their case load. The district nursing teams did not use an acuity tool and patients were allocated to a district nursing team by a case load manager on a daily basis taking into account skills of the team and requirements of the patients.

There was no formal escalation processes in place to address periods of high demand however we were told that there were weekly meetings to look at operational pressures and ensure there were sufficient staff in those areas most in need.

Detailed findings

Incident reporting, learning and improvement

- The service had a robust reporting system in place and staff felt able to report incidents and raise concerns in a 'no blame' culture.
- Incidents were reported using the electronic 'Safeguarding' system. We saw that when an incident occurred a full analysis of the issues was recorded and actions were planned to prevent similar incidents.
- Staff we spoke with were confident about how to report serious incidents and they told us there was an open 'no

Good

Are services safe?

blame' culture when reporting incidents. We saw from staff meeting minutes that incidents and learning were discussed regularly and staff were encouraged to engage with the process.
- During 2014 adult community services had reported 771 incidents; the majority were low grade incidents.
- The trust monitored pressure ulcers, falls and catheter care using the 'NHS safety thermometer'. We could see from 2014 monthly data that incidents resulting in harm were minimal.
- In adult community services a theme in relation to pressure ulcers had been identified in reported incidents. As a result the trust's tissue viability steering group had facilitated the management of thematic reviews and actions in relation to pressure ulcer incidents and associated skin damage (i.e., incontinence or moisture lesions). The group had established a culture of learning with feedback and lessons learned being shared from serious incidents. It also incorporated a peer review process for the review of grade two pressure sores.
- Patients who had been referred to the community nursing services with existing pressure damage present were reported to the commissioners through a regular feedback report from the patient safety team upon transfer back to community adult services. In addition pressure ulcers present on transfer from other organisations were reported back to those organisations, again through an established regular report.

Duty of candour

- In November 2014 the duty of candour statutory requirement was introduced and applied to all NHS trusts. The trust had in place a policy relating to these new requirements.
- Staff we spoke with were able to explain their understanding of the requirements of duty of candour, although some staff were unaware of the requirement.

Safeguarding

- Staff training data showed that over 93% of staff had completed level one training for safeguarding of adults and children.
- Staff we spoke with were confident in reporting safeguarding concerns and were aware of how to escalate concerns to a designated member of the safeguarding team.
- As the system for reporting concerns was also known as 'Safeguard' reporting this could have caused some confusion. Existing staff were clear about the difference but this was not always clear to external observers of records.

Medicines management

- Few medicines were kept on site at each location but those medicines that were, such as adrenalin for emergency use, were stored securely and at the correct temperature.
- Medicines were given in line with prescriptions and all medicines given were appropriately checked and recorded. We saw that when a medicine was given to a patient they were told what that medicine was and asked for their consent prior to administration.
- We saw that the trust had a transcription of drugs policy which was in line with the Nursing and Midwifery Council standards. This ensured that medication could be safely given in the absence of a new prescription based on two pieces of evidence currently on record such as discharge letters, transfer letters or copying patient administration charts onto new charts to improve legibility.

Safety of equipment

- The environments varied from one location to another, however, locations were predominantly used for staff offices and workspaces rather than clinical care.
- Areas used for clinics were spacious and specialised couches and chairs were used to ensure patients were in safe, comfortable positions for treatments. In two locations where the service did not regard the standards to be of equal quality to others plans were in place to relocate the services to more acceptable settings, for example, the leg ulcer clinic was due to move to Dr Piper House in Darlington from its current location.
- We saw that equipment that required regular servicing, such as syringe drivers, was serviced in line with manufacturers' guidelines. Other electrical equipment was PAT tested yearly. Equipment such as weight scales or machines for reading blood pressures were calibrated regularly.

Good

Are services safe?

Records and management

- The trust was moving to an electronic system to record care and support teams. At the time of our inspection records were managed differently between the various teams and divisions throughout the trust. The majority of teams were using paper-based record systems.
- Staff completed electronic records. We observed 12 records and all were complete on the system and could be accessed by all health professionals involved in the patient's care.
- Patient-held records were kept in patients' homes. These were largely seen to be incomplete. Most noticeable was a lack of care planning and risk assessments. We were told, and observed, that some staff took a print out of the electronic records to use on visits. We found this placed the patient at additional risk. The trust was piloting mobile devices in a small number of district nursing teams and in those cases the single record was clear, up to date and accurate.

Cleanliness, infection control and hygiene

- The service had infection prevention and control policies in place. We looked at infection control systems and practices and found that the trust's infection rates were similar to other community trusts across England.
- There were no recent attributable MRSA or Clostridium-difficile infections.
- During the inspection we observed good hand-hygiene and infection-prevention practice within the specialist nursing clinics and emergency care centres and by staff in patients own homes. Data showed that 95% of staff had received hand-washing training and over 88% had had a satisfactory hand-washing assessment.
- We saw that staff followed the 'bare below the elbows' trust policy and national guidelines, and that they washed their hands between patient contacts. Alcohol gel was available for staff, patients and visitors at each location. We saw staff using personal protective equipment such as aprons and gloves when required.
- We observed nurses using safe aseptic technique during procedures.
- The majority of patient care was provided to people in their own homes. Staff minimised the risks of cross contamination when providing care in these environments by keeping products for use by one person only in the person's home.
- In clinical areas we saw that the environment was clean and well-maintained. There were adequate facilities for the safe storage and disposal of equipment and clinical waste.

Lone working

- The service had a lone-working policy in place and implemented procedures to reduce the risks to staff working alone.
- Visits were recorded in real time by telephone contact with a call centre and ended by calling back. Staff were actively encouraged to use the system, which was monitored by management, and staff were rewarded for highest usage of the system.
- We were told by staff that the system worked as, if staff failed to call back in for any reason, they would receive a call and were reminded to deactivate the monitoring.

Mandatory training

- Mandatory training was managed centrally and training places were booked for staff at appropriate intervals. We were told by staff and managers that the system worked well and ensured that all mandatory and role specific training was up to date.
- Mandatory training records showed that 96% of staff had received statutory and mandatory training or were booked to complete it before the end of March 2015.

Assessing and responding to patient risk

- We saw from the electronic records that risk assessments were completed for each patient and the working environment. These included risk assessments for pressure ulcers, nutrition, falls and mobility.
- During home visits we attended we saw that staff undertook holistic assessments, including the key risk assessments for nutrition, pressure ulcers and falls.

Staffing levels and caseload

- Staffing vacancies at the time of the inspection were less than 3% and were proactively managed. We saw that there were no long-standing vacancies in the teams that we visited nor were there any identified risks due to staff vacancies.
- Staff told us that there were usually sufficient staff to meet the needs of the patients, but at times of staff sickness and holidays they could be busy and that sometimes impacted negatively on patient care being

Good

Are services safe?

given in accordance with patient wishes. However, we were told that staff worked well together to ensure that all patients were seen and that caseloads were prioritised.

- Patient case loads varied between the community teams with case loads of between 266 patients at Derwentside and over 1700 patients in Darlington. Individual case loads were similarly varied, ranging from 220 at Derwentside to over 400 in Darlington.
- The district nursing teams did not use an acuity tool and allocation of patients was undertaken by the case load manager. Allocation took into account the nursing skills and capabilities of staff and was carried out on a daily basis in accordance with the needs of the patients.
- There was variation in the provision of community matrons with some areas having access to matrons and other areas no longer having access to this role due to differing commissioning arrangements.
- There were no formal escalation processes in place in community nursing, however, we were told that there were weekly meetings during which the management team would review service pressures and make changes to staffing as required. Staff were moved to areas where workload pressures were greater.
- The service had a number of standard operating procedures that supported the management of referrals and workload. These included 'Managing of referrals for district nursing service' and 'Handover of patients to out of hours service'.

Major incident awareness and training

- There were business continuity plans in place for all eventualities, such as loss of building or utilities. The continuity plans ensured that urgent and high risk patients could be identified and care could be maintained.
- We were told of a recent incident when a building had to be vacated urgently and the service resumed at an alternative location without adverse impact on patient care.
- Staff were aware of the trust major incident policy and were aware of their roles and responsibilities if such an incident were to be declared.

Good

Are services effective?

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

Summary

Care provided was in keeping with trust- and service-specific policies and procedures. Standardised treatment plans were used for certain conditions and these included referenced national guidance and best practice. We saw that staff used care planning and care pathways based on current evidence-based guidance to effectively manage patients' health needs.

There were sufficient, suitably qualified, competent staff to meet the needs of the patients. Staff had regular appraisals and had their training needs met.

There was positive multidisciplinary working across and between services and different professionals, which provided effective outcomes for patients.

Detailed findings

Evidence based care and treatment

- We saw that care provided was in keeping with trust- and service-specific policies and procedures. Standardised treatment plans were used for certain conditions and these included referenced national guidance and best practice.
- There was clear and frequent evaluation of care plans, including wound assessments, to ensure that treatment was having the desired effect. We saw that there was clear rationale ny change in treatment or for more specialist assessments when required.
- We were shown that a service evaluation was completed in collaboration with the Council for Allied Health Professional (AHP) Research. All patients attending the service between February and August 2014 completed a variety of outcome measures. This evaluation demonstrated statistically significant improvement in quality of life, walking distance, anxiety and depression scores and breathlessness.

Pain relief

- A recognised assessment tool supported by national guidance was used to support the review of patients with pain symptoms. We found care plans indicated whether a review was required. Pain assessments were completed for patients as part of a holistic assessment
- Our observations of staff administering care and treatment and our review of patient records confirmed that patients were assessed appropriately for pain symptoms. We observed staff administering a range of pain relief including via the use of syringe pumps in the patient's home. A significant number of community-based nursing staff were independent prescribers and were able to ensure pain relief was prescribed according to individual need.

Nutrition and hydration

- A recognised assessment tool supported by national guidance was used to review the appropriateness of patients' nutrition and hydration. We observed that assessments were completed appropriately. The service monitored monthly the proportion of patients assessed for nutritional requirements at their first visit. Care plans were in place for nutrition and hydration.
- Community and specialist nursing staff referred patients to a dietician where the need for additional support and advice on appropriate treatment was required; for example, for diabetic patients.

Approach to monitoring quality and outcomes of care and treatment

- Audits were used to monitor patient outcomes such as the monitoring of wound care. We saw that when a wound did not respond to treatments within expected timescales specialist advice was sought and action plans were implemented.
- We found that standard operating procedures were followed by staff but there was an absence of 'follow through' and outcomes were not always recorded, which made benchmarking patient outcomes systematically difficult.

Good

Are services effective?

Competent staff

- The service actively supported staff to take on additional roles and further their experience. Independent non-medical prescribing was actively encouraged. On-going support was offered to staff undertaking extended roles.
- Community staff were often required to carry out interventions that required further training, such as the management of syringe drivers and administering intravenous medicines (e.g. antibiotics). Staff told us they were able to access relevant training courses easily and had no concerns about keeping up to date with clinical skills.
- Staff told us that training was managed centrally and training places were booked for them at appropriate intervals. These training places were booked and staff were notified 12 weeks in advance so that managers could be notified and staffing rosters could be updated. We were told by staff and managers that the system worked well and ensured that all mandatory and role-specific training was up to date.
- All the staff we spoke to told us that they had received regular appraisals that were linked to individual training and development plans. Information that we received confirmed that over 90% of staff had had appraisals.

Multi-disciplinary working and coordinated care pathways

- The service provided a number of 24-hour, seven-day services including district nursing and the intermediate short-term intervention service (ISIS).
- District nursing was covered from 8am to 8pm by day staff with night being covered from 8pm to 8am by rotational staff. Although the staff on night duty did not always feel included in decisions the rotational nature of the night shifts ensured a whole team ethos.
- In 2014 ISIS was launched in collaboration with Durham County Council and the clinical commissioning groups to provide a 24/7 single point of access for patients to appropriate health and social care support. Access to sitters, equipment and placements in nursing beds was made available through this service.

Availability of information

- Information to support staff practice and live information about patient care and treatment was available through the trust intranet, which also provided access to external internet sites. Staff felt the trust computer system provided an excellent source of information to support their work. Clear, comprehensive evidence-based content was available on the website for all clinicians.
- We reviewed a sample of information on the trust intranet that staff used to support their work. The information was clear and accessible. Staff also received corporate emails with team briefings, newsletters and other updates about particular themes on a regular basis.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Patient consent was sought appropriately and correctly. Verbal consent was obtained before care was delivered. We reviewed consent information for a random sample of patients as part of our review of records and found this was obtained and completed correctly.
- We saw from training data that over 93% of staff had received Mental Capacity Act and deprivation of liberty safeguarding training.
- Staff told us that they had received training in the Mental Capacity Act, deprivation of liberty safeguarding and consent, which suggested the data was correct.
- We were able to determine that staff had a good working knowledge of the Mental Capacity Act and knew how to raise concerns about the deprivation of liberty for individuals.

Good

Are services caring?

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

Summary

Patients and their relatives were treated with dignity, respect and compassion. We saw numerous examples of compassionate care and patients' dignity and privacy being respected. All the patients and carers we spoke with told us they valued the service and felt that they worked in partnership with the staff.

Patients and their carers received emotional support from staff during contacts and this was highly valued by both staff and patients.

Patients were treated in their own homes or at clinics and services were provided to prevent hospital admissions. We saw that patients were supported when they were moving between services and we observed positive inter-professional relationships.

Detailed findings

Dignity, respect and compassionate care

- During our inspection we observed patients and relatives being treated with dignity, respect and compassion. We observed caring, compassionate care being delivered. Staff were seen to be very considerate and empathetic towards patients, their relatives and other people. Staff shared a good understanding with patients.
- When delivering care and treatment staff respected patient confidentiality. Confidentiality was maintained in discussions with patients and their relatives and in written records and other communications.
- We undertook 14 home visits and observed three patients at one leg ulcer clinic. We saw that people were treated with kindness, dignity and respect. We observed staff introducing themselves to patients and explaining the care to be undertaken during contact.
- We spoke with 24 patients and without exception the feedback we received was overwhelmingly positive; one person described the district nurses as 'angels without wings'.
- We saw that care was centred around the patient and that interventions were coordinated to ensure that care was seamless between the services.
- Staff spoke with patients in a kindly manner and took time to listen to them. We noted that staff knew the patients well and asked about significant people in the patients' lives by name.
- One person who had been visited by the district nurse for four months for wound care told us that she had been a nurse herself, and said that the nurses undertaking her care had always been professional, always arrived on time and were able to answer all questions.

Understanding and involvement of patients and those close to them

- We observed that staff demonstrated good communication skills during the examination of patients. Staff gave clear explanations and checked patients' understanding. We observed staff appeared to understand patients' symptoms well and related injuries to patients' occupational needs and function.
- Patients and their relatives were involved in care planning and their wishes were respected. We were told by patients that care was mainly delivered at a time that was suitable to them.
- We saw that full explanations were given to patients and information leaflets were used to support communications and allow patients and their families time to consider and respond.
- We observed the care of one patient and saw him negotiate with the nurse the rotation for injection sites. He told us, "I am always treated with dignity and respect and I have an excellent care package."
- We saw evidence of compliments and in the second quarter of 2014/15 the service had received a total of 578 compliments, mainly in the form of thank you cards and letters.

Emotional support

- We observed staff providing emotional support to patients and to relatives. Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for patients where this was needed.

Good

Are services caring?

- Staff told us that part of their job was to provide emotional support not just to patients but also to their carers and families.
- On home visits staff clearly demonstrated knowledge of people and their unique situations. We saw staff remaining positive but sympathetic to individuals' concerns. Staff spoke with people in a very calm and reassuring manner without being overly optimistic.
- We saw that family members and significant others were also included in the assessment of need, and staff were responsive to families' physical and emotional needs.
- We observed the care of a patient in her home. She told us that her daughter had unexpectedly died and the nurses supported and cared for her at this time of distress. Support included care by specialist palliative care nurses, aromatherapy and massage through the hospice.

Good

Are services responsive to people's needs?

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

Summary

People's needs were met through the way services were organised and delivered.

We saw that services were planned and delivered to meets the needs of the local population, taking full account of the diverse nature of the locality.

Services were delivered flexibly according to individual needs and wants.

We found that complaints were addressed at the lowest possible level. When complaints were identified lessons were learnt and disseminated effectively throughout the service.

We saw that individual needs were met with care being delivered at the right time by the right professional.

Detailed findings

Planning and delivering services which meet people's needs

- County Durham and Darlington Foundation Trust covers a population in a wide geographical setting with many distinct communities. Services were organised and planned around the natural communities and clinics were used in areas of high population.
- Patients were treated in their own homes or in clinics, and services were provided to prevent admission to hospital for patients who could be cared for in the community.
- Patients' individual needs were met and they were supported when moving between community services by effective electronic and verbal communication and positive working relationships between professionals.
- Various integrated care pathways were used, such as the diabetic foot pathway, which demonstrated good patient outcomes.
- We were told by staff that community contracts would be re-tendered in 2015. Although staff were being kept informed by managers on a weekly basis this was a period of uncertainty and staff felt they had little influence over the process.

Access to the right care at the right time

- Patients were given contact numbers for services and information leaflets. Patients were able to contact community nursing services 24/7. We were told by staff that equipment could be accessed 24/7 as the clinics had a buffer stock of frequently used items of equipment. We were also told that large items such as beds could be accessed out of hours as rental beds could be ordered from a contracted third party.
- Services had been adapted to meet the needs of patients, such as the community matrons having changed their operating hours from Monday to Friday 9am to 5pm to 7 days per week 8am to 8pm to improve patient access.
- Patients told us that they were always able to contact the community nurses when they needed to.
- We were told that one clinical commissioning group had decommissioned its community matron service. Staff expressed concern about equality of service access across the county and possible future impact on other services.

Meeting people's individual needs

- People's individual needs were well met by the delivery of patient-centred care. All services worked well together and coordinated to ensure the best possible care was given.
- We were told by staff that patients who were terminally ill and expressed a preference for a place to die would be supported to achieve their preference in a compassionate manner. We were told that the hospital could discharge the person with all medication required within 1 hour, and that staff in the community could greet that person in their home with all equipment in place in 4 hours.
- Staff told us they were able to refer promptly to other agencies should they require additional support. Staff spoke about good professional relationships with general practitioners and most said that they had that good relationship.
- We observed the care of a patient in their own home. The patient and their family were central and staff delivered care according to the needs of the family.

Good

Are services responsive to people's needs?

- We were told that the intermediate short-term intervention service (ISIS) team responded to patients within two hours in the event of a health crisis and within one day for hospital discharges.
- One patient told us that he couldn't fault the nurses that cared for him, but, although they usually visited in the morning as he requested, he thought the service could be improved by giving an exact time in advance.
- Brochures and leaflets for some, but not all, services stated that the information in the document was available in other formats and languages other than English.
- Staff we spoke with had received mandatory training in equality and diversity.

Referral, transfer, discharge and transition

- Referral to community health services followed agreed pathways of care. Referrals were from a variety of services including GPs, practice nurses, district nurses, patients being discharged from hospital wards who required intervention, complex cases in nursing homes, residential homes, police and prison services. District nurses could refer patients urgently for assessment to the rapid response service in order to prevent a hospital admission.
- Discharge arrangements from hospital were supported by community teams.

Complaints handling and learning from feedback

- Staff we spoke with were aware of the local complaints procedure and were confident about dealing with complaints as they arose. All staff we spoke with told us they tried to deal with complaints immediately and would always say sorry to the complainant. As a result of early stage resolutions there were few formal complaints.
- Minutes from staff meetings showed that issues from complaints and concerns were discussed regularly and practice was altered to improve patient experience.
- There were eight complaints during 2014. The level of complaints was low in comparison with the 540,000 contracted contacts per year.

Good

Are services well-led?

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

Summary

The leadership, governance and culture of the service promoted the delivery of high quality person-centred care.

All members of staff were aware of the vision and strategy for the trust and their service and could relate their roles to achieving this.

Governance and quality measures were embedded in the service. Audits were widely used to monitor quality and receive patient feedback.

Leadership within the service was strong and visible and staff demonstrated a clear respect for local leaders.

The culture within the service was positive and all the staff we spoke with spoke highly of their teams and line managers.

Detailed findings

Service vision and strategy

- The trust vision and strategy of 'right first time every time' was well understood by all staff that we spoke with. Everyone could relate the vision to their own service area and believed that on the whole this was achieved.
- We were told by managers that there were close working relationships with the commissioners and many high level service developments were undertaken together.
- The strategy of providing care closer to home was well understood and its relevance to their service was appreciated by staff. The strategy included the need to further integrate clinical services and develop community services in localities to ensure they would reflect the needs of the local population.

Governance, risk management and quality measurement

- Governance structures were clear to both staff and managers and there was a local risk log within the division.
- Community services maintained a risk register. The register was reviewed regularly and some staff were aware of the risks in their service area, of the action taken to mitigate risks and the role of the corporate risk manager. However, other staff we spoke with were unaware of the risk register or felt it was not readily accessible.
- The managers and clinicians had completed a range of audits which we saw were mainly positive. In areas where results were less positive we saw that action plans had been developed to improve outcomes.
- A professional forum had been established within the care closer to home directorate, which brought together all specialties. The forum centred on the quality agenda and had a key focus on sharing lessons learned and best practice across a range of clinical specialties.
- Clinical governance meetings were held monthly and recorded. We reviewed copies of minutes from the three most recent meetings. Items covered included risks, audit, and a nursing update, which comprised, for example, actions which had been put in place to address an increased reporting of falls incidents.
- Managers and staff told us that regular locality and team meetings were held and were also attended by specialist nurses. Our review of documents showed that these meetings were recorded and included case discussion. Actions taken were documented and reviewed in subsequent meetings.

Leadership of this service

- Staff felt there was clear leadership at executive level and the executive team were approachable.
- Managers and team leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was mainly effective and staff said their direct line managers were supportive.
- Staff were mainly positive about the clinical leadership they received and about the practical ways in which their clinical role was supported by the trust.

Culture within this service

- The culture within the service was positive and confident. Staff told us it was an open culture and that

Good

Are services well-led?

they were encouraged to report concerns or incidents on the basis of 'no blame.' The service was open and transparent in reporting incidents and was actively looking at ways to improve.

- Staff told us that communication within community services was very good and communication between community services and the rest of the trust was good.
- All the staff we spoke with were positive about the contribution they made to patient care and were very positive about the teams they worked in.
- We were told about 'floor Fridays' when senior managers would work on the front line providing direct care to service users. This culture of working alongside staff was seen as positive and kept managers in touch with everyday issues.

Fit and proper person requirement

- The introduction of a statutory fit and proper person requirement applied to NHS trusts from November 2014. The trust had in place a policy relating to these new requirements.

Public and staff engagement

- Across inpatient and community services a clinical quality improvement framework (CQIF) had been implemented. This initiative enabled teams to review quality standards against a framework and provided a selection of improvement tools for the team to use. The framework built in patient feedback and comments, which were seen as vital for the improvement of services.
- We were told by managers that, on a yearly basis, executive and non-executive directors were transported around the county meeting staff and service users to get feedback and engage with front line staff.
- We were told about developments that had been undertaken jointly with commissioners where the public had been consulted. These involved using the clinical commissioning group's public engagement team, the public and representative front line staff. This approach to service redesign enabled services to meet best practice models and ensure good patient access and uptake.

Innovation, improvement and sustainability

- In response to identified issues with pressure ulcers the tissue viability steering group within the trust had initiated a number of service improvements. These included the development of a pressure ulcer guidance card which had been distributed to all community nursing teams and community hospitals.