Somerset Partnership NHS Foundation Trust

RH5

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5X5	Dene Barton Community Hospital		
RH5F5	Minehead Community Hospital		
RH5Y7	Priory Health Park		
RH5F7	Shepton Mallet Community Hospital		
RH5Y8	South Petherton Community Hospital		
RH5F8	West Mendip Community Hospital		
RH5F1	Williton Community Hospital		
RH5X9	Wellington Community Hospital		

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

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
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

During this inspection, we found that the services had addressed the issues that had caused us to rate safe, effective and well led as requires improvement following the September 2015 inspection. The rating for community health services for adults in caring remains the same as in 2015 (good). Effective, responsive and well-led have all changed from requires improvement to good. Safe has changed from inadequate to requires improvement.

Community health services for adults were now meeting Regulations 9, 17 and 18 of the Health and Social Care Act (regulated Activities) Regulations 2014.

We rated community health services for adults as **good** because:

- There were effective incident reporting systems in place and staff reported they received feedback and learning from these.
- The duty of candour regulation was understood by staff and we saw evidence which supported this.
- Staff had good knowledge of safeguarding procedures and felt supported in raising any safeguarding concerns.
- Good medicine management protocols were in place to keep patients and staff safe.
- There was access to equipment for clinic settings and for patients in their own homes. We saw equipment was maintained/serviced as required.
- All clinical areas we visited were clean and tidy and free from clutter.
- Staff reported good access to mandatory training.
- In the patient records we reviewed we found in most cases, risk assessments for example, frailty scale, falls risk, malnutrition universal screening tool (MUST), and skin assessments had been completed and reviewed.
- We found multidisciplinary working was embedded in practice across the adult community services.
- The lone working systems in place kept staff safe. Staff were very aware of the policy and adhered to it.
- Patients' needs were assessed and care and treatment delivered in line with relevant legislation, standards and evidence-based guidance.
- Staff were knowledgeable about assessing patient's mental capacity and cared for patients in a non-judgemental manner, respecting the rights of individuals.
- Some services collected information about patient outcomes and could demonstrate the effectiveness of their service
- The service participated in national audits, audits requested by commissioners and internal audits. The service used the results to review and improve services
- Staff were qualified and had the skills to carry out their roles effectively. Staff had regular appraisal and supervision, including out of hours and overnight staff.
- Multidisciplinary team working was embedded throughout the service and referrals to different healthcare professionals were coordinated and efficient.
- Consent was obtained for care and treatment interventions in line with policy and guidance.
- Feedback from patients was consistently positive, patients went to great lengths to tell us about their positive experiences.
- We saw patients who were active partners in their care, and were encouraged to give their opinions of their planned treatment.
- Care that we observed was person centred, with patient's wellbeing at the heart of care.
- Patients received care from staff who treated them with dignity and respect.
- Staff involved patients in exploring their options, and respected the patient's wishes and requests.
- The needs of patients were taken into account when planning and delivering services. Staff were flexible to meet the needs of patients.
- Reasonable adjustments were made for people with disabilities, learning difficulties and those living in vulnerable circumstances.
- Teams worked very well together to provide the most appropriate care at the most appropriate time for patients.
- Patients were given information about how to make a complaint or raise a concern. There were systems in place to evaluate and investigate complaints.
- Staff were aware of the organisations values and strategy.
- There was strong local leadership in place. Most staff felt able to approach their managers.
- Staff were positive about the executive team and found them visible and approachable.

Summary of findings

- There were governance and risk management systems in place.
- There was a positive, supportive culture across all staff groups we spoke with.
- Patients were asked for their views of the service and how it could be improved.
- The trust worked with local commissioners to ensure the needs of the local population were being considered.
- Staff were innovative and worked with external organisations to examine where local improvements could be made.

However:

- The wound assessment tool available on the electronic patient record system was being reviewed by the specialist nurses for tissue viability and the leg ulcer service, district nursing lead and the clinical lead for the electronic patient record system. However we saw inconsistent practice in how wounds were assessed and recorded into paper based documentation in patients homes and on the electronic patient record system.
- Some cupboards used for storing dressings and medicines were not always within the expected temperature ranges. This meant that staff may be using items that were not safe.
- Sharps bins in use were not always labelled with hospital details and specific area in which they were being used. This meant they would not be traceable to an area if there was an issue when being disposed of.
- Not all the emergency trolleys we saw had in date equipment stored on them. In some areas, a systematic check of the trolleys was not documented as having being carried out on a daily basis.
- Not all staff in clinic settings washed their hands between patients or cleaned the examination couch between patients.
- There was not yet an acuity (dependency) tool in place across the trust to enable senior staff to see each team's dependency ratings and assure staff were deployed to the area's most in need of help.
- Mobile phone coverage remained patchy meaning staff did not always receive messages in a timely way.
- Staffing levels remained an issue for some teams and specialities. Recruitment was ongoing.
- Community nurses were able to photograph wounds to assess progress or deterioration of wound healing with their current mobile phones. However there were some ongoing issues with information governance and storing photographs on mobile telephones.
- We did not see a corporate chaperone policy. We did see information in patient leaflets and on the organisations website that a chaperone could be requested when attending outpatient facilities.
- Waiting lists for some services were long. Staff had waiting list initiatives in place to reduce waiting times for patients.

Summary of findings

Background to the service

Information about the service

Somerset Partnership NHS Foundation Trust provides community adult services across Somerset**.**

The community adult's teams provided care and support in people's own homes, care homes, local health centres, clinics and community hospitals. Community nursing was provided 24 hours a day, seven days a week. Rehabilitation and reablement services were provided seven days a week.

We spent three days meeting staff members of the community based teams. We also met with and visited some patients and their carers and relatives in their own homes.

We spoke with a range of people during and after the inspection. These included community nursing and allied health professionals managers, senior community nurses, community nurses, health care assistants, consultant physiotherapists, senior physiotherapists, physiotherapists, senior occupational therapists, occupational therapists, podiatrists, pharmacy technicians, rehabilitation support workers and exercise instructors. We attended multidisciplinary meetings, complex care meetings and community nurse handover meetings.

We looked at 30 paper-based care records and electronic patient records. We observed care in clinics, joined community nurses and therapists on home visits and we visited balance and exercise classes, stroke and after stroke clinics. We spoke with 118 staff. We spoke with 75 patients in person and by telephone following the inspection, and seven relatives/carers.

Prior to and following the inspection visit we reviewed information requested by CQC and sent to us by the organisation. During the inspection we looked at patient records and associated documentation and observed some care and support provided in patients own homes.

When the CQC inspected the trust in September 2015, we found that the trust had breached regulations. We issued the trust with requirement notices for community health services for adults. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

• Regulation 9 HSCA (RA) Regulations 2014 Person centred care

• Regulation 17 HSCA (RA) Regulations 2014 Good governance

• Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Our inspection team was led by:

Team Leader: Gary Risdale, Inspection Manager (Mental Health), Care Quality Commission

The community adults' team included three CQC inspectors and a variety of specialists: two community nurse managers, a tissue viability nurse and a physiotherapist.

Why we carried out this inspection

We undertook this inspection to find out whether Somerset Partnership NHS Foundation Trust had made improvements to their community health services for adults since our last comprehensive inspection of the trust in September 2015.

When we last inspected the trust in September 2015, we rated community health services for adults as requires improvement overall.

We rated the core service as inadequate for safe. We rated effective, responsive and well-led requires improvement and good for caring.

Summary of findings

Following the September 2015 inspection, we told the trust to make the following actions to improve community health services for adults:

- The provider must ensure that patients receive a thorough and timely assessment that includes essential observations and risk assessments that are necessary to detect deterioration in patients' health and wellbeing.
- The provider must deploy sufficient staff to meet the demand in the district nursing service
- Check e-rostering in all district nurse federations
- Check caseload zoning across all federations and set guidelines for best practice groups
- The provider must ensure that a safe protocol for lone working at night time is actioned and embedded and audited regularly
- The provider must ensure that record keeping is of a consistently safe standard

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 9 Person centred care

Regulation 17 Good governance

Regulation 18 Staffing

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 Somerset Partnership NHS Foundation Trust 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 28 February and 1 and 2 March 2017. During the visit we talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We did not carry out an unannounced visit.

We looked at 30 paper-based care records and electronic patient records. We observed care in clinics, joined community nurses and therapists on home visits and we visited balance and exercise classes, stroke and after stroke clinics. We spoke with 118 staff. We spoke with 75 patients in person and by telephone following the inspection, and seven relatives/carers.

Prior to and following the inspection visit we reviewed information requested by CQC and sent to us by the organisation. During the inspection we looked at patient records and associated documentation and observed some care and support provided in patients own homes.

What people who use the provider say

During the inspection we spoke with a number of patients who had used community services. They told us:

"everyone's lovely and really kind";

"couldn't ask for better";

"I feel safe in their care"; and

"I wonder how nurses keep smiling".

Good practice

- The 'after stroke clinic' at South Petherton Community Hospital had volunteers involved in assisting patients under the direction of the qualified staff. Some of

these volunteers had suffered a stroke and they were able to share their experiences with patients. One patient told us this was beneficial to them after their stroke to see how they could improve.
- The trust ran balance and safety courses over eight weeks with follow up at the end of the sessions to encourage people to continue their exercises at home. They were very well attended. Patients we spoke with were very positive about the service.
- Orthopaedic assessment service sessions (OASIS) ran from several locations across the trust. They were delivered by specialist physiotherapists and podiatrists in collaboration with local GPs and orthopaedic surgeons from the local NHS trusts. We observed two clinics. Staff made a thorough examination of each patient, discussed their presenting condition and their treatment options in depth and were very clear about what was to happen next, for example a scan or referral for surgery.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

- Ensure cupboards used for storing dressings and medicines are within the expected temperature ranges.
- Ensure sharps bins are always labelled with hospital details and the specific area in which they are being used.
- Ensure all the emergency trolleys have in date equipment stored on them. Also that a systematic check of the trolleys is carried out and documented on a daily basis.
- Ensure all staff in clinic settings wash their hands and clean the examination couch between patients.
- Ensure an acuity (dependency) tool is in place across the trust to enable senior staff to see each team's dependency ratings.
- Ensure staffing levels and waiting lists continue to be monitored to ensure safe working practices.
- Ensure community nurses are able to photograph wounds to assess progress or deterioration of wound healing.
- Ensure there is a corporate chaperone policy available to staff.
- Ensure the wound assessment toolkit that is currently being developed is continued and rolled out at the earliest opportunity.

Action the provider COULD take to improve

Somerset Partnership NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We re-rated safe as requires improvement because:

The service had addressed the issues that had caused us to rate safe as inadequate following the September 2015 inspection. In 2015 we rated safe as inadequate, but at this inspection we found large improvement had been made, however we still had some concerns so the rating has been changed to requires improvement.

We rated the safety of the community adults services as requires improvement because:

- The wound assessment tool available on the electronic patient record system was being reviewed by the specialist nurses for tissue viability and the leg ulcer service, district nursing lead and the clinical lead for the electronic patient record system. However we saw inconsistent practice in how wounds were assessed and recorded into paper based documentation in patients homes and on the electronic patient record system.
- Some cupboards used for storing dressings and medicines were not always within the expected temperature ranges. This meant staff may be using items that were not safe.
- Sharps bins in use were not always labelled with hospital details and specific area in which they were being used. This meant they would not be traceable to an area if there was an issue when being disposed of.
- Not all the emergency trolleys we saw had in date equipment stored on them. In some areas, a systematic check of the trolleys was not documented as having being carried out on a daily basis.
- Not all staff in clinic settings washed their hands between patients or cleaned the examination couch between patients.
- There was not yet an acuity (dependency) tool in place across the trust to enable senior staff to see each team's dependency ratings and assure staff were deployed to the areas most in need of help.
- Mobile phone coverage remained patchy meaning staff did not always receive messages in a timely way.

Requires improvement

Are services safe?

- Staffing levels remained an issue for some teams and specialities. Recruitment was ongoing and the risks were recorded on risk registers.

However:

- There were effective incident reporting systems in place and staff reported they received feedback and learning from these.
- The duty of candour regulation was understood by staff and we saw evidence which supported this.
- Staff had good knowledge of safeguarding procedures and felt supported in raising any safeguarding concerns.
- Good medicine management protocols were in place to keep patients and staff safe.
- There was access to equipment for clinic settings and for patients in their own homes. We saw equipment was maintained/serviced as required.
- All clinical areas we visited were clean and tidy and free from clutter.
- Staff reported good access to mandatory training.
- In the patient records we reviewed we found in most cases, risk assessments for example, frailty scale, falls risk, malnutrition universal screening tool (MUST), and skin assessments had been completed and reviewed.
- The lone working systems in place kept staff safe. Staff were very aware of the policy and adhered to it.

Detailed findings

Safety performance

- The service participated in the national safety thermometer and achieved consistently positive results. Data on patient harm was reported each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered incidences of trust-acquired (new) pressure ulcers; patient falls with harm; urinary tract infections; and venous thromboembolisms (VTE).
- We spoke with a senior member of staff who monitored all incidents of pressure ulcers in the community. Community teams had reported 199 pressure ulcers between April and December 2016. Each was graded from two to four (four being the most serious). All pressure ulcers reported via the incident reporting system were reviewed to make sure the correct treatment and equipment was in place.

Incident reporting, learning and improvement

- The provider had systems in place to report incidents and near misses. There were a total of 981 incidents between March and November 2016 reported by Community Health Services for Adults. All incidents were reviewed and investigated if required.
- All staff we spoke with showed an awareness of the need to report adverse incidents and we observed staff completing incident reports. Staff were able to give examples of the types of events that may need reporting and why the service used an electronic reporting system to report incidents. Staff described the system as easy to use.
- All staff, whether based in a community hospital/health centre or out in the community, said they were able to access the incident reporting system easily.
- Some staff told us they did not always get individual feedback when they reported incidents, but did not feel this was always necessary. Other staff told us they were provided with email confirmation the incident had been received and also received feedback from their manager. Themes from incidents that had been reported were shared at team meetings where appropriate, and learning shared.
- A band seven team lead at Bridgwater described an incident report of a death following sepsis. Investigations had shown it was a surgical wound that had opened up. No wound assessment had been completed. Actions had been to reintroduce wound assessment charts and documentation on the electronic patient record system. The tissue viability nurse was leading on this work and had set up a working group to look at it. Band five staff had discussed sepsis at their meetings, how to recognise it and how to use the relevant documentation correctly.
- Another incident related to issues with administration of end of life medicines. Changes following this included the introduction of weekly palliative care hub meetings, where existing and new patients were discussed.
- All grade two or above pressure ulcers were reported as incidents. This included where patients were referred to them from other providers with the pressure ulcer. Grade three pressure ulcers or above were investigated to look at why they had developed or deteriorated.
- Staff told us they incident reported staffing issues when it was felt levels were not safe. We did not see any evidence of negative impact on patients due to the staffing levels.

Requires improvement

Are services safe?

- Senior staff described and showed us how they managed incident reports. When a member of staff reported an incident via the electronic system, it was sent to the manager for that service and they reviewed and investigated the incident. Minutes of a variety meetings that we reviewed detailed learning from incidents and 'near misses'. If an incident involved a medicines error, these were also reported to the medicine management team. Senior staff told us they encouraged staff to report incidents as they were seen as learning opportunities and not about blame. Staff were also required to write a reflective account following an incident to help with their learning.
- We saw posters displayed around the trust detailing learning from incidents, for example, the most reported incidents: pressure ulcers, violence and poor discharge. Learning included checking skin, risk screening, discussion with teams and escalating any poor discharges to a manager.

Duty of Candour

- Staff we spoke with had a good understanding and knowledge of when to apply the duty of candour. Staff told us this was about being open and honest with patients when something went wrong and apologising to them. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) was introduced in November 2014. This regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied.
- We saw information about duty of candour displayed on some notice boards in community nurse bases.

Safeguarding

- The trust had adult and children's safeguarding systems in place to keep patients and staff safe. Staff were aware of the systems and how to report concerns. The trust policy was accessible to all staff via their intranet and staff knew where they could find this.
- Safeguarding risks were highlighted to staff using an electronic alert system on the electronic patient record system.
- Since the last inspection, an updated safeguarding pathway had been introduced for staff to follow when making a referral. The pathway included information, how to access further support and the referral form .The completed form was automatically sent to the local council safeguarding team and the trust's safeguarding team. Staff had access to the pathway via their intranet. Senior staff told us that levels one and two training for safeguarding children and adults was now mandatory.
- There was 96% compliance with adult and children's safeguarding training against a trust target of 95%.
- Level three safeguarding adults training covered female genital mutilation (FGM).
- A recent example of making a referral was discussed with the community nursing team in Crewkerne. Staff told us of the effectiveness of the safeguarding team in supporting the community nurse team when they were deciding if they needed to make a referral.
- During a multidisciplinary team (MDT) meeting in one area, staff discussed a safeguarding referral that had been made for advice on protecting staff when a patient took drugs during a home visit. It was suggested the patient visited a clinic for their treatment.
- In another case a concern had been raised about a patient who was heard swearing aggressively at a child. All cases had been thoroughly investigated and appropriate action put in place to protect patients and staff.
- Staff in integrated teams were having supervision sessions that included any learning and a debrief if the staff member was involved in a difficult safeguarding issue.

Medicines

- Some community nursing staff were able to administer medicines using patient group directions (PGD's), for example to administer flu vaccinations. PGD's provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). The PGD's we saw were in date.
- Medicines we saw were stored in locked cupboards with the keys stored securely. Medicines and dressings were ordered by adult community teams individually from a pharmacy stock list drawn up by the trust.
- We checked some medicines carried by community nurses and found they were in date.
- Medicines that we saw on emergency trolleys were in date and kept in tamper proof packaging.

Requires improvement

Are services safe?

- An audit of the use of syringe drivers within the trust had taken place. The audit used patient records to review 37 episodes of care using syringe drivers. The audit found areas that needed improvement and areas of good practice. Action to address the areas of concerns, for example additional training for community nurses, was planned to take place and a re-audit was planned for later in 2017.
- An electronic prescribing system pilot was underway in several community nursing teams. During one of the team meetings, staff were invited to give their feedback about this, which was mostly positive. Some nurses had concerns about the lack of a prescription chart for specific medication. This was going to be fed back to the staff leading the pilot.
- We went on some home visits with the community pharmacy technician. Visits included support and advice on how to manage a medicines compliance device (blister pack) with a patient and their relative. This included the reason for the medicine, its potential side effects and how to use the 'blister pack'.
- A pharmacy technician said there was about one medicine incident reported per month. A recent one involved a patient being discharged with antibiotics in a blister pack, despite the medicine having been stopped prior to discharge from hospital. There was no harm to the patient and the incident was reported and investigated.
- The store room used by the Crewkerne community nursing team at the Crewkerne Health Centre was very warm. This had resulted in the medicines storage refrigerator being too hot at times which meant some medicines were not always being stored at the recommended temperature. Staff said the issue had been ongoing and had been reported via the electronic incident reporting system in the past.

Environment and equipment

- In some teams we visited we saw a spreadsheet of equipment held by the team, which provided the date of the last maintenance check/service. The maintenance department checked equipment and put labels on with an identification number which staff could use to identify when checks were due.
- Medicines storage refrigerators we saw had had their temperatures checked daily and the results documented. Staff knew who to contact if their refrigerator temperatures were outside the expected ranges.
- Storage cupboards containing dressings were monitored by community team staff that ensured stock was rotated and was within expiry date. The temperature of the cupboard at South Petherton Hospital should have been between five and 25 degrees centigrade. It had been below five degrees a number of times over winter 2016. Staff contacted dressings manufacturers for advice and were advised to check dressing packs for any indications of degradation.
- Therapists told us equipment was easy to access, regularly maintained and serviced and replaced as required. Gym equipment we saw in therapy rooms was labelled to show they had been checked and the ones we saw were in date.
- We saw that equipment used on visits to patients in their own homes, for example blood glucose monitors, sphygmomanometers (used for measuring blood pressure) and thermometers, were labelled as calibrated.
- There were emergency call bells in most consulting rooms. Staff in all areas we visited knew where emergency call bells were and the emergency procedures for their particular area.
- Not all of the sharps bins in use were labelled with hospital details and the specific area in which it was being used. This meant they would not be traceable to an area if there was an issue when being disposed of.
- Not all the emergency trolleys we saw had in date equipment stored on them. For example, at South Petherton there were scissors which had expired in July 2016, an airway size 6.5 expired December 2016 and an airway size five expired February 2016. This was escalated to the matron and immediate action was taken. The resuscitation trolley was signed as checked for most dates, but 19 and 17 February had not been checked.
- Staff ordered equipment for patients, for example, pressure relieving mattresses and beds, from an external supplier. Staff we spoke with, including out of hours staff, said the service was good and they were able to get equipment they needed for patients. Any specialist/expensive equipment had to be agreed by a senior manager. Staff said senior managers were quick

to respond to requests. Staff were able to request same day, overnight and/or weekend deliveries, although deliveries cost more when requested at these times. There was not a problem getting the required equipment.

Quality of records

- The organisation used an electronic patient record system. This was available to staff at clinic bases and remotely for staff carrying out home visits to patients. The system allowed staff to look at notes colleagues from the organisation had written previously. Remote workers had to return to their office base to download information to the main computer system so records could be kept up to date.
- We reviewed 30 sets of records (mostly electronic) and found in most cases risk assessments (for example frailty scale, falls risk, malnutrition universal screening tool (MUST), and skin assessments) had been completed and reviewed. Progress reports were completed at each visit and care plans had been reviewed and adapted to the patients' changing needs. There was guidance available about risk assessment tools in use for nurses to follow, and staff used professional judgement to identify and assess risks.
- Community staff, including therapists and nurses, completed the electronic patient records at the time of the home visit, either in the house or in the car before moving onto the next patient. We saw outcome boxes and pathways were completed, and also an evaluation of the visit. Community staff left folders in patients' homes that included information patients needed, for example nurse contact details, a plan of care written in a way the patient could understand and details of how to raise concerns or make a complaint. The folders were checked and updated at each visit. Some staff completed patient records when they were back at their base as it was more efficient for them.
- Staff told us the computer system enabled them to download their work from their base and then write up their notes without having to access the system remotely. Once back in their hub this information was able to be downloaded on to the main computer system.
- Senior managers told us 90% of care plans were now on the electronic patient record system.
- The District Nurse Best Practice group had developed guidance for staff about which paper records were to be kept in the patient folder in their own home. This included sepsis monitoring and baseline observations, for example blood pressure and temperature. Staff were aware of the guidance and where to access it.
- Individual teams carried out quarterly audits and additional checks as required of their electronic and paper records to ensure they were completed, in addition to an annual clinical audit of record keeping. For example Shepton Mallet community team were 100% compliant with the trust's standard for record keeping meaning all their MUST, skin assessments (wound assessments were not included in this audit) and observations had been completed.
- At our last inspection we identified that wound care records were not completed thoroughly within the community nursing teams. We reviewed six patients' wound care records in detail and found they contained no evidence of wound mapping, photographs or clear descriptions of the wounds to assist with ongoing monitoring, in either the paper or electronic patient records system. Care plans were in place but these were brief and contained only what dressing to use. There were no details to state if the wound had improved or deteriorated. Senior staff told us wound assessments and evaluation records in paper form were available to be used and should be in patients' homes. We did not see them in use consistently. We were not able to establish what impact this may have had on individual patients. Following the inspection the trust told us a 'Service Development and Improvement Plan' had been established that would be ongoing throughout 2017/18. This was in preparation for a proposed CQUIN relating to improving wound assessment. The CQUIN (Commissioning for Quality and Innovation) payments framework was set up in 2009/10to encourageservice providers to continually improve the quality ofcare provided to patientsand to achieve transparency.CQUINs enable commissionersto reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect patients from healthcare associated infection. The provider carried out regular audits to assess compliance with best practice.

Requires improvement

Are services safe?

- Policies and procedures relevant to infection control practices were available to staff on the organisation's intranet. Staff were able to find these when we asked to see them
- The trust carried out hand hygiene audits monthly. A health care assistant (HCA) observed staff with five patient contacts and detailed when they washed their hands during each contact. If results were below 93% staff were asked for any mitigating reasons. Staff were informed if they had been non-compliant.
- Personal protective equipment (PPE) was readily available to staff. We saw staff on home visits and in most clinic settings using PPE (gloves and aprons), washing their hands or using hand gel between patients and creating a clean area for dressings to be done.
- Staff followed the trust policy on being bare below the elbows when completing tasks with patients and when in clinical areas in outpatients departments.
- During a home visit to see a patient who lived in a care home, we observed a member of staff from the care home come into the room and step over the sterile field the community staff member had laid on the floor ready to change their dressing. This meant there was a risk of cross infection to the patient. This was discussed with the community staff member and was going to be fed back to the care home following our visit.
- In the clinics we observed, most staff cleaned equipment in between patient use, for example chairs, sports equipment and dressing trolleys. They used specialist cleaning wipes to reduce the risk of cross infection. In some clinic settings staff did not wash their hands or clean the examination couch between patients.
- Staff disposed of clinical waste in outpatients using the correct coloured bins to prevent the risk of cross infection.
- Clinic rooms in a variety of locations we visited had hand wash sinks, elbow taps, paper towels, liquid soap, and pedal bins available.
- In clinic settings we were told if there were any spillage of body fluids the cleaners were contacted and they were very quick to respond.
- Individual team's cleaned equipment before it was sent for maintenance or repair.
- We saw clinicians who used single use instrument packs disposed of them correctly.
- Clinical areas we visited were clean, free from clutter and free from odour.
- Patients told us they were confident the people looking after them maintained high standards of hygiene.

Mandatory training

- Senior staff told us they had a monthly training report which showed which staff needed to be booked on to mandatory training because it had expired, and those whose training was due to expire. Staff and their line managers were also sent reminder e-mails when they needed to book onto mandatory training. Managers discussed any training issues in one to one meetings with staff. As of December 2016 91.9% of staff had completed their mandatory training.
- Some staff said mandatory training could sometimes be cancelled due to workload pressures.
- Mandatory training was to be completed by all community and clinic based staff. For example, an exercise trainer at South Petherton hospital told us they had completed safeguarding, duty of candour, deprivation of liberty (DoLS), Mental Capacity Act (MCA) 2005 and data protection training. Other mandatory training included fire safety training, moving and handling and infection control.
- Most community adult teams, including nursing, therapists and rehabilitation staff, told us they were able to attend mandatory training as part of their working days. Overnight waking staff told us they could complete some mandatory training on line during their working hours. If they had to attend face to face training during the day, they got paid or received time off in lieu.
- Training compliance in the musculoskeletal (MSK) physiotherapist team was 96.5%, this was above the trust target of 90%.

Assessing and responding to patient risk

- Staff completed risk assessments as part of the electronic patient record. These included nutrition (MUST), skin assessment and falls. In the patient records we reviewed we found most risk assessments were up to-date. We saw care plans had been reviewed and updated.
- We saw that patient allergies had been documented in patient records in their own home and on the electronic patient record system

Requires improvement

Are services safe?

- Community nursing staff showed us details of the National Patient Safety Alerts meeting of January 2017. As a result, diabetic specialist staff cascaded information about the correct use of pre-filled insulin pens to all relevant staff.
- The trust used the National Early Warning Score (NEWS). This tool is used to aid recognition of deteriorating patients, based on scored observations including temperature, pulse, blood pressure and respiratory rate. A high total score activated an escalation pathway, which outlined actions required for timely review, to ensure appropriate interventions for patients. These were clearly documented on the form. We saw a community nurse carry out observations on a patient complaining of symptoms. As a result of the NEWS score, the nurse, after discussion with the patient and their relative, contacted the GP to inform them of the patient's condition.
- Community nursing teams had a daily handover and safety brief meeting. Staff discussed the patients they had seen that day including any changes to their condition, new risks and possible solutions. The multidisciplinary nature of working meant that staff were able to refer to and seek specific support, for example from tissue viability staff or the falls team. The safety brief included details of learning from incidents, new policies and new best practice recommendations.
- SBAR (situation, background, assessment, recommendation) is a communication tool designed to support staff in sharing clear, concise and focussed information about a patient's condition. This was in use, by clinicians, across the trust and was said to be working well. Staff we spoke with used it at daily handover meetings and commented that it did help to organise information to be discussed.
- We attended multidisciplinary meetings where new patients and any associated risks were discussed.
- We attended a multidisciplinary complex care meeting. Six patients were discussed and the meeting followed the trust's protocol for integrated teams' complex care meetings. Cases were presented by lead clinicians and a multidisciplinary approach was taken to risk manage patients. This ensured patients were referred to the right services and for ongoing management. Each person was clear about their role, and in one case immediate actions were taken to ensure patient safety.
- We heard a nurse following sepsis guidance to advise a patient who had a slightly raised temperature about when to contact their GP if they felt unwell.
- The wound assessment tool available on the electronic patient record system was being reviewed by the specialist nurses for tissue viability and the leg ulcer service, district nursing lead and the clinical lead for the electronic patient record system. However we saw inconsistent practice in how wounds were assessed and recorded into paper based documentation in patients homes and on the electronic patient record system.
- We saw the leg ulcer assessment tool being used. It Included the percentage of necrotic tissue, amount of slough, if granulating, size in centimetres, any exudate and signs of infection (odour, pain, increase in size). We saw this was being completed and progress reported upon. Some nurses were unsure if a wound assessment plan was needed alongside a leg ulcer assessment. We saw a nurse measuring size and depth of a leg ulcer to assess progress.
- Podiatrists at South Petherton hospital performed nail surgery requiring a local anaesthetic, once a week. There was an anaphylaxis (extreme and severe allergic reaction) kit in the room.
- An early warning trigger tool was used by band six nursing staff. This was completed monthly and highlighted risks the nursing team might be experiencing, for example increased number of incident reports, complaints, if a new manager was in post, vacancies, cancellation of staff supervision and if more than 20% of patients on case load were zoned as red (meaning the patient needed more care and/or support and may have a number of complex issues to manage). This report went to the relevant manager for information and actions. The early warning trigger tool 'red flags' were to be reviewed following the decommissioning of community nurses carrying out continuing health care and funded nursing care assessments on 1 March 2017.

Staffing levels and caseload

- Staffing levels and skill across the adult community services were adequate to meet the needs of the patients they looked after.
- The South Petherton community nursing team were expecting a vacancy in June 2017. They were hoping to

recruit to this post and have no dip in the staffing levels. One health care assistant left and was being replaced with a band four associate practitioner. There were no administrative staff for this team.

- South Petherton community nurses had nine extra patients to see on the Monday of the week we were inspecting, due to reconfiguration of teams. There were no extra staff allocated to help, therefore two staff worked two additional hours each to cope with the extra workload and make sure patients were seen. This was raised, by the staff involved, to a manager as a concern. We were not told if any action had been taken as a result of this being raised.
- The community nursing team manager in Crewkerne had recently been appointed to the post. They had reviewed the duty rota and caseloads, and discussed skill mix with their team. As a result, staff told us they were able to visit all their patients, complete the patient records and meet daily to have a handover and safety brief meeting. However, this was described as a challenge due to the team being short of a trained nurse. The team were just (March 2017) able to advertise for a trained nurse, despite the previous post holder leaving in December 2016. It was not clear why there had been a delay in advertising the post.
- The trust were introducing rotational posts for new therapy positions, to make the therapy workforce more flexible and increase opportunities for staff.
- Bridgwater community nursing team were reviewing their skill mix. One healthcare assistant (HCA) was training for an assistant practitioner band four post. They had two trained nurse vacancies that they were interviewing for in March 2017, at which point the team would be up to full establishment.
- Another team leader was aware of the vacancies in their team and had readjusted the duty rota to improve skill mix whilst they waited for the new members of staff that had been recruited, to start.
- We observed where a member of staff from a team went off sick at short notice. The nurse in charge rang around other teams to find additional help and all staff helped where they could.
- To help address the issues of qualified nurse vacancies, the role of nursing associate/assistant practitioner was being developed (this was a health care assistant with additional training). An apprenticeship scheme was also in place. It was hoped staff who had completed their apprenticeship with the trust would continue to work for them and develop along a career pathway. Phlebotomy (blood taking) staff were also employed to manage routine blood tests.
- Since our last inspection, senior managers told us they had introduced robust caseload management. Staff we spoke with agreed this was in place and that it had helped to discharge patients off their caseloads.
- We spoke with one community team who felt they did not have enough staff to safely meet the needs of their patients. The team leader felt the staff were undertaking too many visits each day and that staff worked extra hours, often in their own time, to make sure all patients were seen. They were not sure if they were up to established numbers within their team as this had not been shared with them by senior staff. They said their views about this had been shared with senior management but nothing had changed. No bank or agency staff were being offered to them. We did not see any specific incident reports to confirm this had been reported.
- Staffing levels continued to be escalated to the local and corporate risk registers to ensure ongoing oversight.
- There was an ongoing presence at recruitment fairs to help raise the profile of the trust and encourage people to apply for vacancies.
- Senior managers told us caseload zoning was in place to assess the dependency of patients and ensure teams had allocated higher dependant patients fairly across their teams. An acuity (dependency) tool had been adapted for use across the organisation and was to be 'rolled out' in the near future. This would enable staff to see each team's dependency ratings and assist resource planning to make sure the right staff were deployed to the right teams at the right times. Staff told us they assessed patients on their first visit to determine their rating of red, amber or green, based on criteria of needs.
- From 1 March 2017, community nurses stopped completing the continuing healthcare and funded nursing care assessments. They would continue to assess patients, who may be at the end of their life, for fast track discharge and funding. Nurses we spoke with thought this would free up time to catch up on other assessments they were asked to do, for example continence assessments.
- The Bridgwater hub were assessing the benefits of sharing of administrative staff across the integrated team. The action plan for this was due to be reviewed.

Crewkerne had lost an administrative assistant they shared with another team. The post had not been back filled and as a result the team leader was carrying out a number of administrative tasks. The integrated team based at West Mendip hospital found their administrative staff invaluable. For example, they answered telephone calls, ensured training was booked and organised servicing of equipment.

- Podiatry teams across the trust were fully staffed.
- Community physiotherapy teams reported variable staffing levels with some not able to recruit to posts and others who had been able to recruit overseas staff. This issue was detailed on divisional risk registers.
- The musculoskeletal (MSK) team lead said the team were fully staffed with locums working (three in the South, one in Frome and one in Bridgwater).
- There was one pharmacy technician per integrated rehabilitation team (IRT) team across the trust. They felt not everybody was aware of the service provided, but referrals were increasing. They said they would like to be able to review more patients for the possibility of assessing for self-medicating at home. This may further reduce the caseloads for community nurses in the future.

Managing anticipated risks

- The trust took lone working seriously and had a lone working policy to support staff visiting patients in their homes. Each community based team we visited told us about the systems they had in place to ensure staff were safe, and we saw staff adhering to the policy.
- Following our last inspection the trust were asked to ensure there was safe protocol for lone working at night. The policy contained numerous references to precautions to be taken at night, including parking in a well-lit area and avoiding isolated pathways and subways. We spoke with three members of the overnight waking community nursing team, who said they felt their safety was taken seriously. They said they had a local process in place to ensure staff knew where others were and what time they were expected back. They travelled in pairs when workload allowed. They said there was an on call manager to call if they had any concerns about a person's welfare.
- Community nursing teams discussed anticipated risks in daily handover/safety brief meetings and how to best manage anticipated risks. We observed a handover meeting where nurses discussed the best way to manage a number of patients with different issues.
- There was a 'reablement home support service' in place to help relieve pressures on local hospitals in times of high demand. The aim was to prevent delayed discharge from hospital due to lack of community based therapy and/or care.
- Staff told us that following a risk assessment, they were able to visit patients in pairs for their safety if, for example, there were difficult dogs present or if a patient was aggressive.
- Mobile phone coverage was patchy in places. Staff anticipated difficulties and sometimes used their own mobile phones that had better coverage, or tried to get to a community base to use a fixed phone to make a call.

Major incident awareness and training

- The trust had a business continuity plan. For example, in adverse weather staff were expected to report to their nearest community hospital if possible, to see if they could help. Community patients were prioritised and those staff living nearest to patients were asked to visit if appropriate. There was access to 4x4 vehicles owned by local people and/or volunteer groups to help get staff to vulnerable patients. Patients and their families were kept up to date if staff were going to be late, or not able to visit the patient at all.
- Community staff gave us an example of major incident planning by telling us that if there was a major crash on the nearby motorway, the Taunton community nursing teams would be asked to support the local acute hospital as required.
- Other staff we spoke with were aware of the plans if there was a major incident in their area of work.
- Staff knew where to find the relevant policies on the trust's intranet site, for example fire safety and the severe weather plan. The fire safety plan had little information about how staff managed fire if they were in a patient's home.

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

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

We re-rated effective as good because:

- The service had addressed the issues that had caused us to rate effective as requires improvement following the September 2015 inspection.
- Patients' needs were assessed and care and treatment delivered in line with relevant legislation, standards and evidence-based guidance.
- Staff were knowledgeable about assessing patient's mental capacity and cared for patients in a non-judgemental manner, respecting the rights of individuals.
- Some services collected information about patient outcomes and could demonstrate the effectiveness of their service
- The service participated in national audits, audits requested by commissioners and internal audits. The serviced used the results to review and improve services
- Staff were qualified and had the skills to carry out their roles effectively. Staff had regular appraisal and supervision, including out of hours and overnight staff.
- Multidisciplinary team working was embedded throughout the service and referrals to different healthcare professionals were coordinated and efficient.
- Consent was obtained for care and treatment interventions in line with policy and guidance.
- The electronic patient record system had a 'store and forward' facility. This meant staff could make their entries when visiting patients in their own homes.

However:

- Community nurses were not able to photograph wounds to assess progress or deterioration of wound healing.

Detailed findings

Evidence based care and treatment

- Patients' needs were assessed and care and treatment was delivered in line with relevant legislation, standards and evidence-based guidance. We saw many examples of procedures that staff followed when assessing and planning care, which was evidence based and current. Care pathways were used both by staff visiting patients in the community and also by staff who met patients in outpatient clinics.
- Nursing staff in Shepton Mallet had received information in September 2016, by e-mail, about changes to National Institute of Health and Care Excellence (NICE) guidance NG28 - Type 2 diabetes in adults: management.
- The musculo skeletal (MSK) team lead told us the latest NICE guidance was used for back pain management and the policy had been reviewed in accordance with this. They added NICE guidelines on knee therapy will direct in-service training for lower limbs. The MSK teams had an 'away day' every year and staff were updated about new/amended NICE guidance during the day. This led to general discussion and ongoing learning. The MSK lead told us the teams used medical experts to discuss clinical topics, for example getting the best out of magnetic resonance imaging (MRI) scans, and pharmacists had talked to the teams about pain management.
- The exercise instructor at South Petherton talked about NICE guidelines relating to their role, for example management of back pain.
- South Petherton & Glastonbury (West Mendip) held 'safety and balance' classes for patients at risk of falling. Staff used the Tinetti balance and gait assessment tool and the OTAGO university programme (home exercise or small group exercise designed to prevent falls and associated injuries and improve cognition among older people) to develop their classes.
- South Petherton podiatry treatment was based on national guidance for podiatry. We saw podiatry staff provided foot care information to a diabetic patient which followed NICE guidelines NG19 - Diabetic foot problems: prevention and management.
- We attended the 'stroke' and 'after stroke clinics' at South Petherton Community hospital. They were based

on NICE guidance GC162 - Stroke Rehabilitation for adults. The 'after stroke' clinic was designed to encourage patients to continue with their life and encourage them to improve their fitness to reduce their risk of having another stroke.

- Community nursing teams used recognised tools such as the Waterlow Score (a screening tool used to assess patients' at risk of developing a pressure ulcer) and MUST (a malnutrition universal screening tool) when assessing patients. The care plans we saw were based on individual patient needs, were appropriate and relevant.
- It was acknowledged at our last inspection the trust's method of recording of wounds did not enable accurate monitoring of progression or deterioration of a wound in line with NICE guidelines. The guideline recommends the use of a validated measurement tool such as photography or transparency tracing when assessing wounds. Community nurses were able to photograph wounds to assess progress or deterioration of wound healing with their current mobile phones. However there were some ongoing issues with information governance and storing photographs on mobile telephones.
- Measuring and documenting of wounds was inconsistent across the community nursing teams. A senior member of staff from the tissue viability service told us they planned to undertake a baseline audit of the wound assessment documents used across the trust and put an action plan in place to address any areas needing improvement. A re-audit would then take place. We were not aware of when the re-audit would take place.
- We spoke with a band six nurse who input data into the 'safety thermometer' monthly but did not get information back so did not know of any themes or actions they could take as a result of the audit.

Pain relief

- Pain assessment and management was integral to patient care and treatment. Community and therapy staff asked patients about their pain and how they were currently managing it.
- Pain assessment scores could be recorded on the National Early Warning System (NEWS) chart. Staff felt it was easy to assess their patients, as they knew them and patients would tell them if they were in pain.
- We saw physiotherapists assessing pain using a 0 -10 pain score, alongside a thorough assessment which asked what type of pain it was, what makes it better or worse and what medicine was taken.
- Nurses discussed effective pain management in nursing handover meetings. They also discussed calling certain patients about half an hour before they visited to ensure the patient had taken their pain control medicine so that the dressing change, for example, would not be so painful.
- During home visits to patients we saw individual staff ask patients about their pain and record this in the paper and electronic based notes.
- We heard staff running the orthopaedic assessment service asking patients about their pain and how that impacted on their daily routines. This information formed part of the referral if one was necessary.

Nutrition and hydration

- The malnutrition universal screening tool (MUST) was completed as part of the standard nutritional risk assessment for patients. This helped staff assess the risk of malnutrition, or if patients were losing weight whilst receiving care and/or support from trust staff. This meant that staff could discuss diet, nutritional supplements or aids needed, to ensure patients had a sufficient intake to maintain a healthy weight.
- We observed staff discussing nutrition and hydration with patients and their relatives/carers. The staff members then documented the discussion onto the electronic patient record.
- Community staff told us they could discuss with, and refer to, the trust's dietitians or speech and language therapists if their patients needed a formal assessment of their ability to eat and drink, or about nutritional needs.
- There was information about the dietetics team and a range of leaflets that were available to download from the trust's website, for example: 'eating well with diabetes', 'are you at risk of malnutrition' and 'diet and pressure ulcers'.
- There was access to cold drinks in outpatient departments we visited and vending machines in the entrances to most of the hospital sites we visited, where patients and their relatives or carers could buy snacks or hot drinks.

Technology and telemedicine

Good

Are services effective?

- There were ongoing issues with mobile phone signals for some community teams. We saw a staff member trying to make a call to a nurse from the office base and their signal was lost. The nurse was then called on her personal mobile phone as this had a better signal.
- The electronic patient record system had a 'store and forward' facility. This meant staff could make their entries when visiting patients in their own homes. When they were back at their base they downloaded the information onto the main electronic system meaning the patient files were up to date and could be accessed by all relevant staff members.
- We saw staff using equipment that assessed lower leg circulation (Doppler ultrasound). This was to assess the most suitable way to treat leg ulcers.
- We were told about a pilot that had suitable patients wearing activity wrist bands to show how much they were moving. This was downloaded to the electronic patient record system and accessed by the GP and other relevant health care professionals working with the patient, so their activity could be monitored. This meant therapy staff could give patients realistic targets to achieve based on their usual activity.
- Community nurses were not able to photograph wounds to assess progress or deterioration of wound healing.
- During a complex care meeting we saw staff were able to access relevant patient's MRI and computerised tomography (CT) scans to help assess their current condition in relation to cognition.
- During an orthopaedic assessment clinic we saw staff were able to access patient's recent X-rays on the screen in the consulting room. During consultations staff showed the patients their X-rays and were able to discuss the results and ongoing treatment required with them.

Patient outcomes

- The trust collected and monitored information about outcomes of treatment for patients. Some specialist services within the trust also collected data for national audits. Internal audits included audits for compliance with infection control policies and quality of records.
- Patient outcome measures (PROMs) are a report on the quality of care delivered to NHS patients from the patient's perspective. We saw the musculoskeletal (MSK) physiotherapy service PROMS (May 2016). The response rate was 33%. The findings overall revealed that 64% of patients demonstrated either a stable or improving health status.
- The podiatry teams participated in the national diabetic foot audit. However, podiatrists we spoke with were not aware of the findings of the last audit or any action plans.
- The MSK service agreed goals with patients. Documentation showed if these goals had been met within expected time frames.
- Physiotherapy clinic staff discussed patient expectations and personal goals and these were documented in the patient records. For example, a patient wanted to resume playing golf. The assessment, plan, exercises and treatment given and the final outcome were all documented.
- Within the community nursing services, patients were regularly reviewed to ensure their needs were best met by the team. For example, patients with long-term conditions would be discussed in multidisciplinary team (MDT) meetings to ensure care and treatment met the needs of patients, or consider if they needed to be referred to other specialist services to improve their personal outcomes.
- For one MDT meeting, the patient was asked how they thought they could make further progress. Staff built a programme around this information, but with added advice that would help them achieve more progress.
- We saw physiotherapists assessed outcome measures at the start of an assessment and then again at the end of treatment to evaluate what had been achieved. This practice was audited annually to show effectiveness of the assessments.
- During home visits with a variety of therapists, we saw goals were identified with patients. These were then detailed in a care plan with expected outcomes for the patient. Additional information about action for the patient to take to make improvements on their expected outcomes was documented within the plan.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment. Registered health care professionals had the qualifications required for their

role. Health care assistants were supported to gain the skills that were required to undertake their expanding roles. Staff had appraisals and supervision with their line managers.

- One of the MSK team leads said their appraisals were 100% complete for their team. They said staff were allocated one and a half hours a month to devote to continued professional development. That may mean, for example, catching up on the latest best practice and reading professional journals.
- Appraisals for the multidisciplinary team (MDT) at South Petherton were up to date. They were completed annually between April and June. Supervision was four to six weekly. Staff were informed by email or their manager when sessions were due. A member of staff had identified specific training needs around amputees and mobility. This training had been sourced and was taking place at South Petherton hospital during our inspection.
- Most community nursing teams, including out of hours teams, told us they were able to have their appraisals and regular supervision sessions. We saw records of clinical supervision, group supervision and individual staff supervision sessions.
- All of of the waking night staff we spoke with said they felt supported by their manager. They were able to have their one to one meetings and appraisals during their working hours. If they had to attend face to face training during the day they got paid or time off in lieu. E-learning could be completed during their working hours
- Nursing staff were supported with the revalidation process. Revalidation for nurses was introduced by the nursing and midwifery council (NMC) in April 2016. Staff were supported via their annual appraisal and supervision sessions. There was also a section on the trust website for each nurse to list their hours of practice and other information needed for revalidation. This could also be sent to the NMC if required.
- Therapy staff were members of their specific professional's bodies and were supported to demonstrate competence in their field.
- Community nursing teams allocated team members to specific link roles, for example: end of life, infection control, tissue viability and diabetes. They attended meetings with specialist nurses and communicated any changes in policy or practice to their teams.
- Community nurses who were proficient at using the new electronic patient record system provided support and guidance to other community nurses on a one to one basis.
- Band seven nurses told us the trust provided competency training modules for staff to achieve 5+ training. Some of this was university based. The 5+ training was not a qualification in district nursing, but provided community nurses with enhanced training to develop their skills.
- We spoke with a band seven nurse who was an independent nurse prescriber. They had clinical supervision from another senior clinician and provided supervision to other nurses who prescribed medicines.
- A band four exercise instructor had completed additional training to support their role. This included lower body training, spinal and upper body and shoulder rehabilitation.
- Senior staff told us about the career progression they had in place for staff bands two to four. One health care assistant told us they had applied to be an associate practitioner, which would mean they would be trained to undertake specific clinical tasks.
- Qualified nurses who worked in ambulatory care told us they had to complete competences to undertake certain clinical tasks. For example, blood transfusions and flushing of PICC lines. A PICC line is a long, thin, hollow tube that is put into a vein above the bend of an elbow and is used for medicines like chemotherapy.
- A band five development programme had been started for nurses to help them progress to become a band six. This was a two-year programme to help them learn about portfolio/caseload management and nurse prescribing. This had been welcomed by band five nurses who said it meant they had opportunities for development.
- We spoke with a senior member of staff from the tissue viability service (TVS) who told us they were about to start training sessions for staff on wound assessment. The TVS also provided leg ulcer management training, which included Doppler studies and compression bandaging. Staff had to complete a number of sessions following the training before being able to undertake these skills independently. Pressure ulcer prevention training was also provided.
- Training on sepsis was available as a two-hour face to face session. This was not mandatory training, but all staff were able to request it.

- There was a monthly 'district nurse best practice group' where best practice developments were shared. This kept managers updated and they cascaded the information to their team leaders and they in turn to their teams. They also discussed relevant new policies and procedures, adapted them accordingly and gave them back to the policies and procedures group to be validated and made available to staff on their intranet.

Multi-disciplinary working and coordinated care pathways

- Staff were positive about multidisciplinary working across the trust. All necessary staff were involved in assessing, planning and delivering care and treatment to a patient. Across all of the services we found multidisciplinary working was part of the care that was provided to patients.
- There were clear referral pathways in place. Staff we spoke with were aware of these and how to access the services.
- Community nurses told us they met with staff from the local hospice fortnightly to discuss any of their patients with palliative care needs.
- Band five nurses were encouraged to attend integrated teams' business meetings. The meetings also included physiotherapists and older people's mental health team members. Patient's progress and any associated issues were discussed
- Some community nurses attended GP meetings three times a week, to discuss patients of theirs they were seeing.
- Some community teams had physiotherapists and occupational therapists located in the same office as community nurses. Staff spoke of how useful this was as they could discuss patients face to face and offer advice and possible solutions to issues with each other.
- We attended some complex care meetings where a number of different professionals met to discuss patients that presented with particular challenges. Each member bought different skills and they were able to work together to suggest ideas for how to manage the patients.
- Community nursing teams told us the tissue viability service was available for advice and would visit patients to assess wounds and suggest the most appropriate treatments.
- A single point of access hub was in place for community nursing teams to receive their referrals from. Referrals were made via e-mail or over the telephone. A member of nursing staff was available to review referrals based on clinical needs. However, some community nursing staff felt this was not taking place, as it should, as not all of their referrals had been assessed by a clinician prior to being allocated to them. Whilst at the hub, we saw the clinician being involved in decisions about patient care and then informing the relevant community nursing team. We also observed the administrator contact a community nursing team directly to discuss a patient and when they needed to add them in for a visit. For twilight shifts and at weekends, a team leader coordinated all work to monitor which teams had most work, so it could be shared out equally.
- Staff at the 'After Stroke' club at Williton Community Hospital had maintained continuity of care with the patients as they had seen them on wards, in their own home and now at the club. They were able to see how they had improved and patients had got to know them.
- We spoke with staff from several care homes we visited. All said the community nursing staff were very supportive and always visited them when they called. They were asked for their input into the patient's care and the instructions they were given were clear and easy to understand.
- Patients at the South Petherton balance and safety class said they found the sessions "fun". One patient told us the session"keeps me nimble".Other patients told us the service "keeps you in contact with people" and "service in Somerset is wonderful".
- Community nursing staff and, sometimes, therapists arranged joint visits with members of the older people's mental health teams and/or social services when needed.

Referral, transfer, discharge and transition

- There were clear and effective processes in place for staff to communicate between teams and when referring patients to other teams or services including general practitioners (GPs).
- We saw records of patients referred, via email, to the community nursing service from GPs.
- Physiotherapists could refer patients to the independent living team (that included occupational therapists (OT), physiotherapists and speech and language therapists (SALT)).

Good

Are services effective?

- Patients could self-refer to the continence nurse and the continence nurse could onward refer to a physiotherapist if necessary. We also saw community nurses referring to specialist services, such as the continence service, following a request from a patient.
- Patients were prompted by GPs and other health care professionals to access the MSK physiotherapy service and may be offered a telephone triage if deemed as beneficial for their needs.
- Exercise instructors received their referrals from physiotherapists and continued to work closely with therapy teams to best support the patients.
- We saw the orthopaedic assessment teams refer patients for scans and to orthopaedic surgeons for further treatment.
- MDT meetings assessed patients regularly for their progress and potential discharge from services or referral to other services for further treatment.
- We were told about the success of the 'homecare reablement service' which enabled patients to be discharged home earlier because care/support was available at home. This not only freed up hospital beds, but aided patient recovery/rehabilitation as they were in a familiar environment. This was a pilot scheme so there was no data available at the time of the inspection to demonstrate the effectiveness of this service.
- Staff from the stroke team worked together and when needed with staff from one of the acute trusts to assess and plan ongoing care and treatment, to assist in the early discharge scheme. Patients' homes were assessed as well as their support network. Once home, they had support from stroke nurses, therapists and psychologists to assist in their recovery.
- The 'out of hours' rehabilitation teams worked different hours in different teams. They worked with existing patients and with hospital discharge teams to support patients coming home who may need some extra support for a short time, at which point they should either be independent, or require a package of care for ongoing support.

Access to information

- The trust's policies and procedures were all available on their intranet system and staff were aware of where to find them. Staff were able to access the information they needed to deliver effective care and treatment.
- The trust used an electronic patient record system. It could be accessed by all relevant staff. Some staff had access to a system that was linked to GP practices and could therefore see all previous consultations with health care professionals a patient may have had.
- Patients being seen by community nursing teams also had a paper record in their house. This included specific information about wound care or medicines charts for insulin or eye drops, information about how to contact the community nursing team and how to make a complaint about their care. There was not always a written record made of the visit in the file, as this could be detailed on the electronic system at the time of the visit.
- We saw nurses using the electronic records system to access patient records before their visit and then updating the records immediately after the visit. Once back at base, the nurses downloaded the information from their laptop computers to the main system so records were kept up to date.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Community nursing staff and therapists spoke with confidence about assessment of a patient's mental capacity and the challenges that could present if patients chose to ignore advice about their choices. We observed staff in a complex care meeting discuss the need to assess a patient's mental capacity to determine if they were in a position to make rational decisions about their care choices.
- Staff obtained consent to care and treatment in line with legislation and trust guidance. We saw patient records where patients had signed to give their consent for treatment. We saw a range of staff gaining verbal consent before carrying out procedures, both in their own homes and clinic settings.
- Electronic patient records alerted staff as to what information patients had consented to sharing and any limitations to the patient's capacity.
- We witnessed a discussion about a patient with severe dementia who was ready for discharge. The best interests of the patient were discussed which were contrary to the relative's choice of care. Staff were knowledgeable about the process and the rights of the patient.
- Nurses and therapists told us they had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty

Good

Are services effective?

Safeguard (DoLS) training. Staff told us if they were in doubt about anything relating to the MCA they would ask advice of the safeguarding team or mental health trained colleagues.

- There were leaflets available on the trust's website that advised patients to let reception staff know on arrival at clinics if they needed a chaperone.
- Clinicians told us chaperones were always available in clinic settings if a patient or clinician requested one.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Feedback from patients was consistently positive. Patients went to great lengths to tell us about their positive experiences.
- We saw patients who were active partners in their care, and were encouraged to give their opinions of their planned treatment.
- Care that we observed was person centred, with patients' wellbeing at the heart of care.
- Patients received care from staff who treated them with dignity and respect.
- Staff involved patients in exploring their options, and respected the patients' wishes and requests.

However:

- We did not see a corporate chaperone policy. We did see information in patient leaflets and on the organisation's website that a chaperone could be requested when attending outpatient facilities.

Detailed findings

Compassionate care

- Patients we spoke with during home visits had very positive comments about the staff that visited them. Quotes included: "everyone's lovely and really kind", "couldn't ask for better", "I feel safe in their care", "I wonder how nurses keep smiling".
- We observed, and patients told us, that nursing and therapy staff across the trust treated patients with dignity and respect and used language they could understand.
- We observed staff maintaining patients' privacy and dignity when carrying out physical examinations in patients own homes and clinic settings.
- We saw therapists and podiatrists introduce themselves to patients and families they were seeing for the first time.
- We observed a balance and safety class in West Mendip Hospital. The rehabilitation assistants running the class were kind and supportive to patients. They attended to patients' individual needs discreetly. They gave clear instruction to patients during the class and were encouraging and enthusiastic. Patients told us they felt a great benefit from the classes, and in all cases they said the sessions had improved their confidence.
- We asked some patients who we spoke with on the telephone following the inspection "What did the staff do well and what could they do better?" Comments included: "They are brilliant and give a lot of care. Will sit and talk and can't think of anything they could do better", "put you at your ease", "I trust them, they know what they are doing and I don't think they could do anything better".
- Patients and relatives we spoke with who received home visits from staff told us that if the member of staff was going to be late, they contacted the patient to let them know.
- Patients and relatives we spoke with told us, and we saw during home visits, staff had time to listen to patients and provided reassurance if necessary.
- We observed staff taking time to interact with patients in a respectful and considerate manner. Staff when undertaking a task, for example wound care, did it at the pace of the patient and did not hurry them. Patients were able to ask questions and staff told them what they were doing.
- We saw staff being caring, sensitive and supportive to patients' needs in their own homes, clinic and group settings.
- Whilst we did not see a corporate chaperone policy we did see information in patient leaflets and on the organisation's website that a chaperone could be requested when attending outpatient facilities. We asked a therapist who said when patients had asked for a chaperone, one was always made available.

Understanding and involvement of patients and those close to them

- Patients were routinely involved in planning and making decisions about their care and treatment.
- All patients we saw in their own homes understood their care and treatment plans. The plans were written in plain English and patients were encouraged to read them.

Good

Are services caring?

- We saw personal exercise programmes discussed with patients and written information provided to support understanding at home.
- During a home visit we observed a nurse discussing options available to improve wound healing. The patient did not want pressure relieving devices and the nurse respected the patient's choice.
- During home visits and clinics we observed, we saw staff communicated with patients so they understood their care, treatment and condition. Patients were involved in their care and were asked for their input when appropriate.
- We heard staff discussing a patient during a complex care meeting, who needed a visit possibly from more than one service. They discussed who was most appropriate to go to ensure the patient did not get too many visits from different people. This was because they knew the person did not like to let people into their house. This demonstrated a person centred approach to the patient.
- We observed a number of daily nursing handovers and safety briefings where nurses discussed concerns relating to patients they had seen that day. There was a 'whole person' approach in the discussions which considered all aspects of the patient's care and welfare This included how to ensure the patient and their relatives were involved in decisions about their care and treatment. Relatives told us they felt involved in their loved ones' care and had established good relationships with staff.

Emotional support

- We saw a therapist carry out a psychological assessment of a patient that identified memory loss. As a result, the therapist gave the patient time to explain their problems and worries and actively listened.
- During home visits, we saw therapy staff empower and support patients to continue to live within their ability and manage their condition at home. They considered the emotional needs of the patient alongside their physical needs.
- Patients receiving home visits from community nurses told us when new staff started they usually came with an existing member of staff to be introduced before visiting on their own.
- We saw emotional support and information was provided to those close to the patient, as well as to the patient.
- We saw evidence of supportive relationships between staff and patients with diagnoses of life limiting conditions. Patients and their relatives told us they felt they could discuss anything with the staff.

Good

Are services responsive to people's needs?

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

Summary

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

We re-rated responsive as good because:

- The service had addressed the issues that had caused us to rate responsive as requires improvement following the September 2015 inspection.
- The needs of patients were taken into account when planning and delivering services. Staff were flexible to meet the needs of patients.
- Reasonable adjustments were made for people with disabilities, learning difficulties and those living in vulnerable circumstances.
- Teams worked very well together to provide the most appropriate care at the most appropriate time for patients.
- Patients were given information about how to make a complaint or raise a concern. There were systems in place to evaluate and investigate complaints.

However:

- Waiting lists for some services were long. Staff had waiting list initiatives in place to reduce waiting times for patients.

Detailed findings

Planning and delivering services which meet people's needs

- Patients at the end of their life, in some areas, were visited by each member of the nursing team early in their care to ensure they and their family were familiar with the team and that seamless care could be provided.
- Teams carrying out home visits said they would try to accommodate patients' needs and book appointments to suit the patient where possible. We heard discussions about timings of patient visits during handover meetings we attended. We were given numerous examples of how different teams worked together to ensure patients received the most appropriate care at the most appropriate time.
- We heard a nurse call a patient to inform them their nurse would be late for the planned visit and gave an indication of the time they should expect the visit.
- Staff knew how to access interpreters if needed. Leaflets were available in different languages and formats, for example large print.
- Senior staff told us that demand for their services had grown by eight percent a year and they were looking at ways of meeting this demand. For example, the use of ambulatory care clinics. This was where patients could attend for appointments (which they could make at time suitable for them), for certain treatments without the community nurses having to visit them at their home. These were in place in Taunton and Williton hospitals. Patients told us this allowed them to get on with their daily lives and go out, without having to wait in for the nurses to arrive.
- A trust wide home care support service was set up since October 2016 to prevent admissions to hospital and to assist with early discharge. An admission criteria was in place and the funding for this had been extended until June 2017.
- The IRT team based at Wellington hospital covered the ward and community. They were a small team and staff reported good multidisciplinary working with local community nursing teams, pharmacy technicians and GPs. The team did not have a waiting list of people to see.
- The community nursing twilight service ran from 5pm to 10pm every day. It was staffed by existing community staff who started later in the day so could continue to work the twilight shift. Staff worked in pairs as many of their patients needed two staff members and it provided safety for staff working out of hours. On duty for each area were a band six nurse and a healthcare assistant, with an administrator to take referral calls.
- There was an overnight waking community nursing service from 9.45pm until 8.15 am, seven days a week. There were three bases with two staff at each base. Staff went out in pairs whenever possible.

Good

Are services responsive to people's needs?

- Balance and safety courses ran over eight weeks. There was follow up at the end of the sessions to encourage people to continue their exercises at home. The classes were very well attended. The aim was to help to prevent people from falling in their own homes.
- Orthopaedic assessment service (OASIS) sessions ran from several locations across the trust. They were delivered by specialist physiotherapists and podiatrists in collaboration with local GPs and orthopaedic surgeons from the local NHS trusts. We observed two clinics. Staff made a thorough examination of each patient, discussed their presenting condition and their treatment options in depth and were very clear about what was to happen next, for example a scan or referral for surgery. There were detailed leaflets about the service available on the trust's own website. The musculoskeletal (MSK) physiotherapy team lead said the clinical commissioning group (CCG) was reviewing MSK services and was planning the commissioning of a new MSK pathway.
- Podiatry clinics ran from 8.30am until 5pm during the week, from a number of the trust's community hospital sites.
- There was a team of tissue viability nurses who provided care and treatment for patients with complex wounds. They received referrals, usually from district nurses, and would arrange joint visits with them to advise, agree a treatment plan and provide supervision of treatment carried out by the district nurses.
- Specialist service clinics (for example podiatry, audiology, cardiac rehabilitation clinics) ran at set times throughout the week in various locations. These services appeared to meet the needs of the local population. Patients we spoke with were all very complimentary about the services on offer and the locations.

Equality and diversity

- Services took into account of the needs of individual patients and were not judgemental in the way they cared for patients. Staff spoke of people's rights to choose a particular way of living.
- We saw a physiotherapist offer a patient with dyslexia a choice of literature about their exercises, in both written and photographic form.
- We saw there were bariatric chairs available for patient use in some clinic sites.
- We were given examples of where reasonable adjustments were made in order to help people with disabilities or learning difficulties. For example, space was made available for those patients who required a carer to remain with them during treatment. Disabled parking spaces were available at all main entrances of the sites we visited. There were disabled toilets in all of the areas we visited.

Meeting the needs of people in vulnerable circumstances

- The service took into account of the needs of different people, including those in vulnerable circumstances.
- We were told appointments were longer if patients had specific needs, such as mobility or cognitive issues.
- We accompanied staff on some home visits. We saw staff took the time to get to know the patients and tailored their appointments to meet their individual needs.
- A physiotherapist identified a diabetic patient at risk of forgetting how much insulin they had administered themselves. The plan was to inform their GP of the medicine risk and also their risk of falls and depression. The patient already had some community support, but the therapist recognised this may need to be reviewed.
- Patients with complex care needs were referred to the Symphony service (a team jointly funded by the clinical commissioning group (CCG) for co-ordinated support of the complex care team).
- Podiatrists told us patients with a form of dementia would be accompanied by a partner or, if necessary, they would book a clinic or community nurse to support the patient.
- There was a facility on the electronic patient record system to alert staff to additional requirements a patient may have, for example hard of hearing or cognitive issues.
- Patients who attended the balance and safety classes we observed told us how they enjoyed the classes, but also the social aspects of the group and sharing their experiences with other people.

Access to the right care at the right time

- Calls were triaged at the district nurse hub and allocated to the appropriate team. Community nursing teams provided a 24 hour service. This was achieved by regular day staff, a twilight service and an overnight waking service that did not have routine patients, but

took referrals from the 111 service. Examples of referrals from the 111 service included patients that needed an urgent visit for pain management or a blocked urinary catheter.

- Integrated rehabilitation teams (IRT) ran services from 8.30am to 4.30pm seven days a week, with some service providing cover until 6pm. IRT teams provided urgent and routine services.
- Patients did not have to wait long for an initial assessment and treatment in most services the trust offered. Where possible, staff accommodated the individual's preference for time and place when booking appointments for clinics.
- Clinics generally ran on time and patients we spoke with said they did not have to wait long on the day of their appointment. If community nurses, specialist nurses or allied health professionals had to cancel home visits, they phoned the patient to explain the reason and to re-arrange the visit.
- Staff accessed equipment via an external provider. The company had peripheral stores with a supply of wheelchairs, so staff had had quicker access to equipment for patients.
- Integrated rehabilitation teams (IRT) in the Shepton Mallett and Glastonbury hospitals had patients who had been referred for routine assessment in December 2016 and had not yet been seen at the time of our inspection. The waiting list was triaged to ensure people with the most pressing needs were seen first. This meant that people who may, for example, need a walking frame could be waiting for a long time and be at increased risk of falling.
- Waiting lists for physiotherapy in Shepton Mallet were well managed. Patients were booked ahead for three to five weeks' time, which meant the actual time of waiting for a first contact was approximately two weeks.
- MSK Physiotherapy at South Petherton had a waiting list initiative to get urgent referrals down to one week and routine referrals down to three weeks. We did not see any data that showed how this was being achieved.
- Exercise instructors we spoke with told us patients were assessed by a physiotherapist and goals were set. Verbal feedback was given to the physiotherapist about the patient's progress. The exercise instructors also gave advice on classes, not run by the trust, like tai chi, or a sport or activity that would help the patient maintain their level of fitness
- Patients we spoke with said they were generally happy with the times in which community staff arrived. The visits we observed were not rushed and patients told us they did not feel they were rushed.
- Staff told us they arranged for cover during periods of sickness. However, this was not always possible and in these circumstances staff worked overtime or visits were rescheduled for the following day. The staff prioritised care for patients most at need.

Learning from complaints and concerns

- Patients' concerns and complaints were listened and responded to in a timely manner. Learning from complaints was used to improve quality of care. The trust had a policy for managing concerns and complaints which was available on their intranet and public website.
- The service had received 11 complaints in the last year. Five related to the community nursing service (two were upheld), two were related to the MSK service (neither were upheld) and one was about the continence service (not upheld). The complaints were thoroughly investigated in line with the trust's policy.
- Senior staff told us how they used learning from complaints to change practice. They told us about a complaint, which was partly upheld. There was learning from the complaint that was shared with all staff. This involved other agencies and they worked together to address the concerns raised. We were shown an action plan and the changes made to policies as a result. A member of staff involved in the complaint told us about the learning from this and how this was shared with their team.
- Staff told us complaints or concerns about their service were shared with them and any learning from them was discussed at team meetings.
- Patients were provided with information about how to make a complaint or raise a concern. Contact details were stored in the notes in patients' homes. We saw this was the case in a number of paper based records we saw during home visits with staff members. In clinic settings and in the trust's community hospitals, details of how to make a complaint were displayed, usually, in the main entrance. The trust's website had details of how to raise concerns or make a complaint through their patient advice and liaison service (PALS).

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

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.

We re-rated well led as good because:

- The service had addressed the issues that had caused us to rate well led as requires improvement following the September 2015 inspection.
- Staff were aware of the organisation's values and strategy.
- There was strong local leadership in place. Most staff felt able to approach their managers.
- Staff were positive about the executive team and found them visible and approachable.
- There were governance and risk management systems in place.
- There was a positive, supportive culture across all staff groups we spoke with.
- Patients were asked for their views of the service and how it could be improved.
- The trust worked with local commissioners to ensure the needs of the local population were being considered.
- Staff were innovative and worked with external organisations to examine where local improvements could be made.

Detailed findings

Service vision and strategy

- The trust's aim was to deliver care to an individual as close as possible to where they live, in local communities and in people's own homes.
- We saw posters advertising the trust's mission statement, visions and values – 'caring for you in the heart of the community' and 'our commitment to care' - around community nursing hubs and offices and displayed in outpatient departments in the trust's community hospitals. The vision for the trust was to be 'the leading provider of community based health and social care'. The trust values were 'working together', 'everyone counts' and 'making a difference'. Staff we spoke with were aware of the visions and values and felt they worked in line with them. Staff did not tell us they had been involved in developing the values. Staff we observed encompassed the values in their work with patients and their families.
- The MSK team lead told us the vision for their service was "to maintain quality of treatment with content staff".
- The trust worked with local commissioners to ensure the needs of the local population were being considered.

Governance, risk management and quality measurement

- There was a governance framework that ensured responsibilities were clear and that quality and risks were understood and managed.
- The trust made clinical policies and guidelines available for all staff via their intranet. These were available to staff at all times. Staff showed they knew how to access relevant policies.
- We were shown the risk register for the trust, which contained some risks relating to the community. A copy of this was available to the community nurses and senior member of staff were able to tell us which related directly to them. In Williton, one of the main risks was the shortage of therapists in the community teams. Staff said they were able to feed their local risks into the corporate risk register, ensuring the board were aware of them. One risk was recently removed from the trust wide risk register: continuing health care (CHC) funding assessments and the time taken for staff to complete them. This was taken back by the CCG on 1 March 2017. This meant community nurses no longer had to complete these assessments and could concentrate on their caseloads.
- Staff at Williton told us they had the increase of insulin injections at weekends detailed on their risk register. One of the actions for this was to share the visits with another community nursing team. We saw the associated risk assessment document.

Good

Are services well-led?

- At our last inspection, issues were identified with the lone working policy and procedure. During this inspection we found this was much improved. Each hub had a list of staff who were on duty each day and each member of staff had to ring or text in to confirm they were on duty and also when they had finished their shift. An escalation procedure was in place if a member of staff could not be contacted and on call managers had access to staff next of kin contact details if required. Staff across the trust confirmed this was an improvement and they felt safer. If a member of staff felt at risk during a visit, they were able to call their hub and say a set phrase that indicated they needed immediate support and the police would be called to attend.
- There was an ongoing problem with mobile phone connectivity. The trust were due to provide staff with specialist mobile telephones that were able to work from two networks, so if one didn't work they could pick up the other network. It was envisaged this would improve the situation for staff working in the community.
- Dashboards were updated monthly and showed, for example, performance on training and missed community nurse visits. The results were discussed at divisional meetings. Action plans were developed and discussed at band seven level and then shared with band six staff.
- Band seven community team leads met monthly. Their meeting agenda included palliative care, local issues, trust issues, serious incidents, duty of candour, audit results for hand hygiene, staffing, safety alerts, NEWS scoring and actions needed. We heard the band seven nurses discussing audit of Malnutrition Universal Screening Tool (MUST records and ongoing actions. Staff were 100% compliant on recording and reviewing the assessment but the pathway was not always documented as followed by staff. The band seven nurses were analysing the possible reasons why.
- Band seven community team leaders attended the district nurse best practice group monthly. They were involved in setting standards for district nurse supervision and the daily safety brief. They were also involved in the monthly case load reviews.
- Feedback from exit interviews when staff were leaving was analysed for trends. We were not made aware of any trends identified in the last 12 months.

Leadership of this service

- Many staff we spoke with had met the new chief executive (CEO). They found him to be approachable and interested in what they did. Most staff read the CEO blog and one person described him as a 'breath of fresh air'.
- Some teams were expecting to have him visit their service in the near future and were looking forward to seeing him.
- Senior staff we spoke with, including divisional leads and senior managers, understood the challenges to provision of good quality care in community settings and could identify the main risks, challenges and opportunities.
- Senior staff told us they were doing shadow shifts with teams both nights and days. This was to enable them to get a feel of how day to day working was and to address any areas of concern.
- Not all staff said they felt well supported by their line managers or their next level of management. Some staff felt they never got to see their line manager, as they were not accessible to all community teams. Therefore, not all staff felt they could approach their managers and discuss their concerns with them. We were not told why staff thought the managers were not accessible to staff. Other staff we spoke with said their line managers were very accessible and supportive and they had a good working relationship with them. We saw this was the case in some teams we visited.
- Managers and team leaders of the community based teams held monthly meetings with their teams. Staff told us they felt the meetings were useful and as a result they felt updated on best practice and any new guidance.
- Therapy staff and allied health professionals felt generally well supported by their service leads and felt they listened to them.
- Community pharmacy technicians we spoke with felt supported by their managers and felt involved in changes across the trust that may affect them.

Culture within this service

- We found a positive culture among the community services we visited. Staff spoke of being proud of their teams and the care and support they were able to provide to patients.

Good

Are services well-led?

- Staff told us the culture in relation to incidents was about learning and not blame. Managers told us they encouraged all staff to report incidents so they could be investigated and any learning from these shared with the staff involved and others if needed.
- We asked staff about opportunities for professional development. They told us they had annual appraisals and supervision sessions and registered nurses had support to complete requirements for their revalidation. Staff felt supported to develop and managers told us they supported people to develop. Allied health professionals told us they had been supported to develop their interests and access relevant training. Staff said generally they felt the trust had a supportive culture and wanted staff to be able to develop their skills.
- A band six physiotherapist who had been deaf since age four years had been supported to work by the trust. They were not able to use the phone and communicated by text and email. They were supported by a rehabilitation assistant when doing home visits. Their phone had a 'find my phone' as a lone working tool so they could be found if they got into difficulty. They felt very supported.
- The trust had a lone working policy and had devised systems that suited each area to ensure the whereabouts of staff, particularly out of hours, was known to members of their team. There were robust systems in place to call team members if they had not made contact when going off duty.
- There was on call management available to all staff between 6pm and 8am seven days a week.
- The twilight and overnight waking community nursing services worked in pairs, when possible, partly for their safety and partly as many of their patient's required two staff to attend to them. One staff member said they felt vulnerable when working on the twilight shift when they had to work on their own. They did not feel supported by their manager on this issue.

Public engagement

- Patients were able to feed back their views on the services provided via the NHS friends and family test, to say if they would recommend the service. Staff told us they were told about the outcomes of this survey.
- We saw Patient Advice and Liaison Service information displayed on posters at the community hospital bases we visited.
- We saw patient feedback survey titled 'Patient Feedback Cardiac Rehabilitation Service 2016' (November). The response rate had been 53%. The conclusions of the report were that "overall feedback remains very positive". The report stated that "themes had reoccurred" and "pertinent comments had been included in the action plan". Patients had said they liked being able to discuss their concerns and problems and meeting people in similar situations.
- We saw the Podiatry Service Patient Related Experience Measure (PREM) Service Summary 2016. The related 'Friends and Family' data showed that 87% of patients would be extremely likely or likely to recommend the service to their friends and family. The conclusions of the survey found there was a theme of clinicians offering a high level of 'patient centred care'.
- We saw the Musculoskeletal (MSK) Physiotherapy Service Patient Related Experience Measure (PREM) Service Summary 2015/16. There was a 33% response rate. The related 'Friends and Family' data showed that 90% of patients would be extremely likely or likely to recommend the service to their friends and family. The conclusions of the survey also found there was a theme of clinicians offering a high level of "patient centred care". The MSK service received 48 compliments, in the form of cards, letters, emails and small gifts such as chocolates, between October and December 2016.

Staff engagement

- Staff were able to contribute to specialist nurses meetings through the link nurse for that specialty, for example diabetes and end of life.
- In Bridgwater, band two staff had been reassessed and upgraded to band three as they were carrying out that role. Their pay was backdated for one year.
- A number of band five nurses attended the electronic patient record system user group to contribute to its development and raise any issues.
- A musculoskeletal (MSK) team leader said they were proud of the service and the ongoing integration of services. They said in-service training was directed by staff. For example, staff said what they would like to study in three half day and one whole day training sessions over a year.
- An exercise instructor we spoke with met the Chief Executive Officer (CEO) at their induction. They received an email welcoming them to the trust and a staff feedback form. They felt engaged with the trust.

Good

Are services well-led?

- A podiatrist we spoke with knew who the CEO was. They felt involved in changes at trust level. They read the 'What's On' monthly staff magazine that gave updates on changes within the organisation.
- The trust had set up 'see something, say something' to encourage staff to report any concerns they might have, but to also report where they witnessed a positive event. A new staff confidential reporting hotline had also been set up for staff to contact if they had any concerns.
- Senior staff told us they had carried out listening events following our last inspection to update staff on the progress they had made on their action plan.
- The Chief Executive had set up two weekly blogs for staff to follow so they could keep up to date with changes in the organisation. Several staff confirmed they read these.
- A pod cast was also made of all board meetings to enable staff to access them.
- We saw a copy of the monthly newsletter set up in the Taunton hub for staff to keep up to date with changes in their area. This was accessible to all staff in this area.

Innovation, improvement and sustainability

- The district nurse best practice group had developed a checklist of what documentation to keep in patient files kept in the patient's home.
- A number of nurses told us they enjoyed being part of a larger team rather than GP based as they were previously.
- The use of ambulatory care clinics across the trust reduced the burden on the community nursing team. Patients were able to ring to book an appointment to suit their needs. Feedback we received from patients about the clinics was very positive.
- Community nursing leaders had found out about best practice nationally by joining the national District Nurse forum and had linked with Oxford community services to see how integrated teams worked in other areas.
- The integrated rehabilitation team (IRT) in East Mendip (Frome) had been delivering dementia awareness training since May 2016 to voluntary drivers, in partnership with a local community transport provider. Both the drivers and the families of those that the drivers pick up have commented on how this has improved the drivers' confidence and the overall service experience.