Rotherham Doncaster and South Humber NHS Foundation Trust

RXE

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)
RXE00	Trust Headquarters - Doncaster		

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

Serious incidents were investigated and feedback was given to staff. Staff used safeguarding procedures appropriately and medicines were managed safely. Equipment for patients was supplied promptly. Infection control procedures were followed and community locations were visibly clean. Staff knew how to escalate concerns.

Community services used and contributed to NICE guidance. Pain relief and nutritional needs of patients were addressed. The tele health service had significantly reduced home visits and admissions to hospital. The service consistently achieved performance and outcome targets. Staff were supported to develop their skills. Multi-disciplinary working was well developed. Access to mental health services was straightforward. Staff appraisals were not up to date and the audit programme required development. Not all staff received consistent clinical supervision. Staff did not always assess capacity or fully document consent.

Patients and relatives were treated with respect, dignity and compassion. Confidentiality was maintained. Patients spoke very positively about quality of care they received. Staff offered clear explanations and checked the patient's understanding. Patients were empowered to engage in self-care. Staff provided emotional support to patients and their relatives and carers.

Services were planned and delivered to meet the needs of patients particularly those with complex conditions. The service met the needs of hard-to-reach groups, the traveller community and bariatric patients. Patients were assessed promptly and referral to treatment times met the 18 week target. Mental health services were accessible. The needs of minority ethnic patients were reflected in service provision. There were few complaints but learning was shared with staff. The needs of patients with dementia were not always considered appropriately.

The leadership of the service was joined up with the executive leadership and staff knew the trust's vision and values. A risk register was in place for the service. Regular governance meetings were held. Managers and staff felt supported by the trust and the service reflected an open and honest culture. Staff opinions were sought. We found examples of innovative and outstanding practice. We identified some concerns in the supervision of Band 5 nurses.

Compliance with mandatory training, including safeguarding training, was below the trust's target of 90%. There were shortages in the permanent staffing of community nursing teams; this was on the corporate risk register. Caseloads for community nurses were higher than planned. Capacity and demand information was used daily to support the movement of staff in response to patient workload; this demonstrated a shortfall in nursing hours or units.

There were gaps in clinical risk assessments and insufficient planning for the review or evaluation of care needs. Risks linked with electronic record systems were being addressed.

Summary of findings

Our inspection team

Our Inspection Team was led by:

Chair: Philip Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

Head of inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Cathy Winn, Care Quality Commission

The team that inspected community adults services included CQC inspectors and community nursing and therapist specialists.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit, we reviewed a range of information we hold about these services and asked other organisations to share what they knew.

During the inspection visit, the inspection team spoke with 74 members of staff, 17 patients and seven carers, reviewed 15 health care records and attended two meetings.

What people who use the provider say

Patients spoke very positively and expressed their appreciation as to the quality of care they received.

Eighty seven percent of patients would recommend the service to their family or friends. As a place to receive care, 79% of staff would recommend the service (as compared with the England average of 76%).

Areas for improvement

Action the provider MUST or SHOULD take to improve

- **Action the trust MUST take to improve**
- The trust must ensure there are sufficient staff to meet the patients' needs within the community nursing service.
- **Action the trust SHOULD take to improve**
- The trust should support staff to undertake their statutory and mandatory training.
- The trust should review risk assessments and reviews to ensure they are completed accurately.
- The trust should review clinical supervision arrangements for all community staff.
- The trust should develop arrangements to support patients with dementia.

Rotherham Doncaster and South Humber 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

Compliance with mandatory training, including safeguarding training, was below the trust's target of 90%. There were shortages in the permanent staffing of community nursing teams; this was on the corporate risk register. Caseloads for community nurses were higher than planned. Capacity and demand information was used daily to support the movement of staff in response to patient workload; this demonstrated a shortfall in nursing hours or units.

There were gaps in clinical risk assessments and insufficient planning for the review or evaluation of care needs. Risks linked with electronic record systems were being addressed.

The service participated in the trust's sign up to safety campaign. Serious incidents were investigated and feedback was given to staff involved in an incident and also to the service. The investigation of pressure ulcers had resulted in learning for staff. Medicines were managed safely.

Community services were co-located with social services to support joined up working. Equipment for patients was supplied promptly. Infection control procedures were followed and community locations were visibly clean. A single point of access (SPA) for community services in Doncaster was commissioned and implemented in June 2014. it was extended to include mental health crisis in September 2015. Staff knew how to escalate concerns about deteriorating patients. Teams planned for changes in demand due to seasonal fluctuations. Each service had a business continuity plan in place.

Safety performance

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and harm- free care. The improvement tool focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients

with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).The service completed the Safety Thermometer monthly; it did not report VTE as part of the safety thermometer.

- The service reported 157 falls with harm, 235 new pressure ulcers and six CUTIs between June 2014 and June 2015. Falls had varied widely month to month, for example just one occurred in November 2014 but 20 in April 2015.
- Numbers and rates of new pressure ulcers had been high during this period with a peak of 25 pressure ulcers in October 2014.
- The service participated in the trust's sign up to safety campaign. The trust executive has set an objective of zero harm for the organisation. The objectives for community services included reducing the number of avoidable falls and the number of avoidable pressure sores. The service had reduced the number of falls, with four occurring in May 2015 and 12 in June 2015 against a peak of 20 in April 2015.
- Staff had been asked to make pledges about what they were planning to do for sign up to safety.
- Staff told us the pressure ulcer audit of completed root cause analysis investigations had provided lessons learned which had been fed back to staff, and gave examples of this, including improvements in wound care.

Incident reporting, learning and improvement

- Between April 2014 and August 2015 the service reported a total of 30 serious incidents in community settings, including in patients' homes. The majority of these (23) were grade three pressure ulcers. Of the total number of incidents occurring in community settings, 21 took place in patients' homes. Incidents were evenly spread across the community nursing teams.
- No never events had been reported.
- The service reported incidents using an electronic incident-reporting system widely used in the NHS. We found staff used the reporting system appropriately to record and report incidents. A checklist had been developed by team leaders to ensure staff followed the correct procedure for reporting incidents.
- The service investigated serious incidents using root cause analysis. Serious incidents were investigated and action plans prepared. We discussed the reports from several investigations with staff. Feedback was given to individual staff where they were involved in an incident. Recommendations and learning were shared with staff through team meetings, newsletters and by email. Improvements identified included the documentation of pressure area care and mobility assessments. The investigation of pressure ulcers had resulted in learning for staff, particularly the availability of dressings and the completion of skin checks on admission to the service. An organisational learning forum was held monthly. The Learning Matters newsletter captured lessons from across the trust, including examples of excellent practice and areas for improvement following serious incidents. Safety alerts were shared with staff.
- Incident forms were completed where staffing levels were considered unsafe and included missed breaks. The most recent incident occurred a month prior to our inspection. The reasons for the incident were reported as recruitment and retention issues meaning staff morale was allegedly being affected. However, the incidence of these was low.
- During our visits to observe staff practice, we observed one instance where the nurse involved in a visit to a patient had not considered the need for an incident report where this was warranted. This was discussed with staff at the time.
- In specialist community services, we were informed that no incidents had occurred that had caused harm to patients, and no serious incidents had been reported.

Duty of Candour

- The Duty of Candour statutory requirement was introduced in 2014 and applied to all NHS trusts. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or significant harm. The trust had a policy in place relating to this new requirement.
- Information to be reported under the Duty of Candour requirement was included in the electronic incident-reporting system. We saw that information about the Duty of Candour was displayed on staff noticeboards in the locations we visited, and was available on the staff

Requires improvement

Are services safe?

intranet. Staff we spoke with were mainly aware of their responsibilities under the Duty of Candour requirement, although this was not the case for some more junior staff, who were still to receive training.

Safeguarding

- The service had a safeguarding adult's policy and procedure in place and staff knew where to access this. Staff we spoke with were able to explain how they applied the policy and demonstrated that they understood and used it as part of their practice by discussing examples they had encountered.
- Overall, 98% of staff in the service had completed safeguarding adults' level one and 57% had completed level two training as at July 2015. The trust's target for training compliance was 90% by 31 December 2015. Community services had provided training for staff in safeguarding adults' level three and four. For example, 60% of eligible staff had completed safeguarding adults' level four training as at July 2015. Where staff had not received training, arrangements had been made for them to attend. Staff also received reminders when they needed to attend update training.
- The contact details for the safeguarding adults team and other relevant details about raising an alert were displayed in the centres we visited.
- During our visits to observe staff practice, we saw one instance where the nurse involved in a visit to a patient had not considered the need for a safeguarding referral where this was warranted. This was discussed with staff at the time.

Medicines

- Medicines were managed safely. We found there were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management. Nursing staff told us that these were readily accessible along with access to pharmacist advice when needed. The service sought advice and support from the trust chief pharmacist.
- Arrangements were in place to ensure that medicines incidents were reported and fully investigated and we found there was an open culture around reporting medicine errors. A medicines incident meeting was held regularly.
- Patient Group Directions (PGDs) were in use across trust sites. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked a sample of PGDs in the district nursing team and saw that they were up to date and had been authorised appropriately.
- Blank prescription forms were handled in accordance with national guidance as these were tracked through the trust and were kept securely at all times.
- We saw a system in place for managing national alerts about medicines safety issues. Records showed that the alerts were distributed by the trust to community teams who highlighted them at meetings and emailed them to relevant staff. Team co-ordinators implemented the required actions to protect patients from harm.
- Community staff said that medicine management training was covered during induction but ongoing medication training was not mandatory. Non-medical prescribers were supervised and had training opportunities relevant to their role.
- Nursing staff in a focus group were unable to confirm that audit of medicines was undertaken for community services. When we shadowed nursing staff during visits to patients we saw that documentation of medicines was completed correctly. We observed that a detailed explanation and advice was given to patients and their relatives regarding medication.

Environment and equipment

- Community services were co-located with social services to support joined up working, although we found this had not been achieved for each location where staff were based. Other services, for example the police, shared facilities at some locations where we encountered some concern as to the provision of safe storage. However, we were assured that files were removed and stored safely in a secure storage area.
- We saw that store rooms in community bases used a traffic light system to ensure sufficient stocks of supplies and equipment were maintained. Staff undertook weekly ordering of replacement stock. However, we

found no separate audit of stocks was undertaken. At one location we saw that boxes of some items of equipment were out of date. Staff we spoke with removed the out of date items during our visit.

- Equipment for patients' use was supplied promptly and maintained correctly. Medical devices were supplied by an external organisation. All staff had access to the supplying organisation. Staff said that no delays were encountered in obtaining equipment. Staff told us they followed the policy. In urgent instances equipment was supplied the same day, and in other instances within an average of two days. Staff knew the procedure and who to contact to request equipment.
- The equipment supplier supported community patients, for example by demonstrating the use of the equipment to the patient and relatives. This could be followed up and repeated if needed by the community occupational therapist. A store/shop at the hospital site was available for patients to purchase smaller items of equipment. We were informed that patients and their relatives knew how to report any issues they encountered with equipment.
- We found that arrangements were in place to ensure the safety of equipment. Staff in a focus group told us that the use of medical devices was monitored and the equipment service completed audits. Equipment we observed was labelled with up to date portable appliance testing (PAT). Equipment calibration had taken place and equipment records checked were in date. Equipment stored in centres was labelled to show when it was last cleaned.
- Specialist staff in a focus group described how patients were supported with adaptations and equipment, which could be commissioned and installed quickly in response to the needs of patients. For example, this may include structural adaptations (within a financial limit) and hoisting equipment. The service worked closely with the local authority in commissioning speciality equipment.
- One relative we spoke with had experienced some difficulty in obtaining pressure relieving equipment from the service and had resorted to obtaining the equipment elsewhere. The difficulties the patient had experienced were discussed with the service during the inspection.

Quality of records

- Community services used an electronic patient record system widely used in the NHS. Within the trust patient records were held using two different clinical computer systems. The significant risks that this presented were reflected in the corporate risk register. A clinical systems review was being undertaken to address these risks, which was due to report to the executive in October 2015. The trust communicated with staff in the service about information and technology developments which affected them through a trust information and technology newsletter ("Connect").
- Specialist nursing staff updated patient records using a different record template and system to community nursing staff, although the information was stored on the same electronic system. Although the system required a new referral to be made for each discipline to record, for example, therapy activity, specialist nursing staff told us they found using the system helpful as they could share and review GP and community nursing notes. However, not all GP practices used the same system.
- Staff in a focus group told us the system usually worked well for them in the office base, but in certain areas they were unable to connect so that for patients in those areas their information could not be accessed and staff resorted to asking the patient for some details. To address poor connectivity and provide access to records in certain areas, staff had received disconnect training in the previous year which allowed staff working in these areas to download information for patients. Staff may need to write up paper notes in the community then transfer to the electronic record on their return to base.
- We reviewed a selection of patient records and care planning information at each of the community locations we visited, and during our observation of patient care. Nursing staff completed data entry in the patient's home on a laptop computer. We reviewed a sample of patient records on the computer system. Initial assessments, risk assessments, care plan reviews and consent information were completed. Patient goals and treatment plans were completed. Referrals were completed electronically and actions taken were

documented. A limited amount of patient record information was kept in the patient's house. Information for patients about their healthcare record was available in a booklet.

- During our observation of community nursing in one area, we found significant gaps in patient information for three patients which the nursing staff had visited in the previous week. There was no evidence that assessments or reviews had been completed. For example, the nutritional assessment for a patient with dementia was previously completed in 2013 and there was no record of a diagnosis of dementia or of any referrals or assessments relating to mental health, memory loss, confusion or cognitive state. A further visit we observed required two staff to move the patient to undertake a full pressure area check but the nurse was unaware of this from the record, so the visit required re-scheduling. We discussed these omissions with nursing staff during our visit.
- At one location we visited, a shortage of computers in assessment rooms, meant that staff used a mixture of paper records and the electronic system, which could delay the completion of patient assessments.
- The mandatory training programme included information governance training. The trust target was 90% by 31 December 2015. Training compliance in the service ranged between 50-83% with an average of 67% of staff trained, which meant that a third of staff were not up to date with training.
- Staff told us that records were audited yearly and this was reflected in the audit plan. A sample of records were audited for each community team. However, the service did not provide evidence of its completed documentation audits.

Cleanliness, infection control and hygiene

- In the Patient Led Assessment of the Care Environment (PLACE) survey 2015 the trust achieved below national average for cleanliness; 95% as against a national average of 98%. However, the trust improved significantly from its 2014 result which was 88%.
- The trust had an infection control policy and staff knew where to locate this. Trust policies were adhered to in relation to infection control. Staff demonstrated that they had a good understanding of infection prevention and control.
- We observed staff during home visits and clinic sessions and saw that correct infection control techniques were followed. We observed that staff had access to personal protective equipment, hand gel and cleaning wipes. Gloves and aprons were used appropriately. Staff completed hand hygiene before entering the patient's home and on leaving. The cleaning of equipment was the responsibility of each member of staff. Clinical staff we observed followed guidelines relating to hand washing and being bare below the elbow. Staff cleaned their hands and used hand wipes and hand gel before and after they provided care. Clinical waste was disposed of appropriately.
- The service employed housekeeping staff to maintain a clean environment. Community locations we visited were visibly clean. Assessment rooms were clean. Infection control information was visible to patients and relatives.
- Mandatory training for staff included infection control. The trust target for infection prevention and control training was 90% by 31 December 2015. An average of 70% of staff were trained in infection control as at July 2015. We reviewed local records which showed staff had received training in infection control. Staff we spoke with confirmed this.
- We observed the environment was very clean in community locations we visited. Cleaning services were in-house and all staff took a role in cleaning. A cleaning checklist was displayed and signed each day; the cleaning checklist was up to date.
- We reviewed examples of infection prevention and control audits conducted in the service. Audits were completed by domestic managers including audits of hand dispensers which were completed two or three times per year. An action plan was prepared following an audit of wheelchair services.
- Nursing staff in a focus group gave examples of previous shortfalls in adherence to infection control techniques

which had subsequently been addressed. For example, the service had identified some improvements in handling wound infections and antimicrobial dressings were available.

Mandatory training

- The trust target for completion of mandatory training was 90% compliance by 31 December 2015.
- Information the trust provided showed that mandatory training completion rates for most teams were significantly lower than the trust overall target of 90% compliance to be achieved by 31 December 2015. The trust notified managers of staff whose compliance with the mandatory/statutory training was not compliant.
- Senior staff told us they faced challenges in releasing staff for mandatory training and also in obtaining accurate records of completed training. The trust submitted information to us on their compliance with mandatory training. Overall this information showed a relatively low level of compliance with aspects of mandatory training. For example, as at July 2015, fire safety was 59%, moving and handling of people was 45% and of objects, 64%.
- The service was not assured from the records that staff had completed the appropriate training and that patients were not at risk. Staff compliance with mandatory training was included on the trust's risk register as staff may put patients at risk as they may not have had the appropriate training.
- We reviewed staff training records available in community locations we visited. Senior staff explained that training took place which was not recorded centrally by the trust, or there was a delay in recording completed training. We found mandatory training was mainly up to date, or arrangements were made for staff to attend training. Staff discussed the completion of their mandatory training at one to one meetings with their manager. It was the responsibility for staff to ensure they were up to date with their training; Staff were encouraged to attend mandatory training and to submit as an incident if mandatory training was cancelled.
- The training schedule was displayed as red when staff were not up to date with training and this was identified three months in advance. We saw a training board in the staff area which contained information about training courses available. This included dates arranged for staff to attend training. The role of the clinical practice educator in each team included reviewing staff records for compliance with mandatory training.

Assessing and responding to patient risk

- A single point of access (SPA) for community services in Doncaster was commissioned and implemented in June 2014. it was extended to include mental health crisis in September 2015. The SPA provided clinical triage and assessment for patients requiring community nursing services. The crisis service was available for people of all ages and accessible 24 hours 365 days a year.
- We observed and listened to the triage nurse in the SPA. For example, the nurse received a call which was identified as the person needing advice. The nurse reviewed the person's electronic record and previous history before they spoke with them. The nurse then spoke clearly, gave the person reassurance and advice and explained that if their situation had not improved in a couple of days they should contact their own doctor. The nurse recorded the phone call in the electronic record.
- In a second example the call had been identified as an emergency as the patient needed a syringe driver putting in place so that they could receive their medication for pain relief. The call handler read the patient's notes and saw they had been receiving care from one of the planned community nursing teams. The triage nurse contacted the planned care team who agreed to put in place the equipment the patient needed.
- We found specialist and community nursing staff knew who to contact to escalate concerns as to deteriorating patients to more senior staff. This included cover provided by a director at weekends.
- We observed staff handover, which we were informed took place daily. The handover included seven members of community nursing staff and their manager. Each member of staff gave feedback about the patients they had visited. The feedback included the treatment the patient had received, for example, change of dressing, psychological support and reassurance. The manager and staff shared their knowledge of the patients discussed and the manager gave advice to

nursing staff. They discussed key risks to the patient and the implications for their safety. When one of the staff expressed concerns about a patient, the manager arranged to go on a visit with them to assess the situation. We observed the escalation of a concern when a patient's condition deteriorated. This was dealt with appropriately by nursing staff and safely escalated to a GP.

- District nursing sisters (Band 6) told us they estimated they saw only 50% of patients who were referred to the team caseload. Some staff expressed concern about patients they were responsible for but had not personally seen; this may present a risk that care needs were not identified.
- During our observation of nursing staff we found there were gaps in clinical risk assessments and insufficient planning for the review or evaluation of care needs. There was a lack of risk assessments undertaken for patients with identified risks and some clinical risk reviews were missed. We requested to review a selection of risk assessments completed for patients. During our observation of handover, we found when risk assessments were discussed senior staff did not clarify what the outcomes were. Review dates of risk assessments were not clear. For example, the date a Band 6 district nurse planned to visit to undertake a reassessment was not recorded.
- Staff in a focus group told us that the service used electronic warning signs on the staff intranet to identify problem areas or addresses; risk assessments of patients were undertaken. The trust communication system sent out electronic warnings routinely; staff could download clinical information prior to visiting a patient which meant that, for example, if connectivity was lost, supporting information was available. Staff used mobile phones and a buddy system to communicate.
- The minutes of the clinical governance group held in August 2015 showed that a pressure ulcer improvement plan had been prepared which reflected the key work streams for the prevention and treatment of pressure ulcers. This was developed from an analysis of serious incident investigations undertaken in 2014-15. During 2014-15, 36 patients in the care of community services developed an avoidable category three or four pressure ulcer, 20 of which deteriorated from a category two. A brief guidance document was available to nursing staff describing what to do when a pressure sore was identified. Nursing staff we observed told us they identified the grade of pressure ulcer and it was graded as three of four, it was passed to senior staff for further investigation. The service were implementing a new risk assessment tool for pressure damage that was adapted from use in another trust. Nursing staff were to receive training.

Staffing levels and caseload

- Doncaster community integrated services was redesigned by service managers during 2015, supported by commissioners, to take account of community nursing capacity and demand and patient complexity.
- Commissioners were also involved in a review of staffing recruitment and retention to address staff sickness and vacancy rates.
- The integration of specialist services also included a series of reviews covering the range of services and reflecting capacity and demand.
- A case management approach was introduced in June 2015 for community nursing services, with a planned caseload of 50 patients per member of staff. Senior staff told us that caseloads were currently higher than this. For some staff groups this was subject to further review, involving commissioners. Staffing and the adjustment of caseloads was reviewed at team meetings.
- Shortages in the permanent staffing of community nursing teams was on the corporate risk register. Recruitment to community nursing vacancies was in progress. At the time of our inspection, in September 2015, the central area team had 11 band 5 vacancies against an establishment of 37.
- Capacity and demand information was used daily to support the movement of staff in response to patient workload. This included workload units for vacancies leave and training, linked to off duty rotas. This showed that in July 2015, there was an equivalent of 8790 units vacant for qualified staff. One 7.5 hour band 5 shift equated to 24 units. We were informed that acuity, duty rotas and dependencies of patients were reviewed daily. A traffic light system was used and shortages were

identified taking account of demand and staffing. Skills and training was taken into account when allocating staff to patients. Some staff were requested to work across the area, although this was infrequent.

- Patients were scored for complexity and those at level four or above were allocated to the Band 6 nursing staff who acted as case manager. Staff we spoke with were supportive of the case management approach; they felt it was easier to get to know patients. We were informed community services nursing teams normally made 12-13 visits per day, with a maximum of 16-17 visits. Planning allowed for travel and data entry. Most teams we spoke with felt visits were manageable.
- Community service managers received a weekly update about sickness and absence rates in their team. Sickness rates had decreased; for example, we reviewed information for one team where the sickness/absence rate was 3.7% (112.5 hours) against a rate 5% (160 hours) in the previous year. Teams told us they worked well together and were able to cover for each other when there was sickness in the team.
- We were informed the service did not use agency staff, but maintained their own internal bank of nursing staff who worked across the service. Part time permanent staff who were willing to work additional hours were requested to have a bank contract to operate alongside their permanent contract. This arrangement supported the training and supervision arrangements for bank staff.

Managing anticipated risks

- Community services teams managed foreseeable risks and planned for changes in demand due to seasonal fluctuations. An emergency planning officer was in post.
- Each service had a business continuity plan in place which was in date and available to staff. The information included action cards for staff to use and had been written by the service and therefore was relevant to their needs. The emergency plan included arrangements to redeploy staff into temporary roles, for example in ward areas.
- Staff in each service were aware of how the business continuity plan for their service linked with the overall business continuity plan for the trust. For disruptions to the service due to adverse weather, for example, plans included meeting the needs of the most vulnerable patients during periods of severe winter weather as well as in adversely hot weather or in other emergency situations such as power cuts.
- Specialist staff in a focus group explained that extending the use of mobile phones and other mobile devices used in the service was the result of reviewing the responses to previous emergencies. These devices were deployed to allow access to records and to support communications under adverse conditions.

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

Community services used guidance from NICE and the Royal College of Nursing. The service contributed to the development of national guidance and the clinical audit programme monitored the implementation of NICE guidance. Patients with pain symptoms were administered pain relief promptly. Patients received a nutritional assessment as part of their first assessment and were referred to a dietician if this was required. The tele health service had significantly reduced home visits and admissions to hospital for patients with certain long term conditions. The service consistently achieved performance and outcome targets. Staff were supported to develop their skills. Multi-disciplinary working was well developed with co-located social services. Referrals following hospital discharge were prioritised. There was good access to mental health services.

The service participated in national and local audits although the audit programme required development. Some staff appraisals required completion. Staff did not always receive appropriate and consistent clinical supervision. Staff demonstrated an understanding of consent, MCA and decision making although we identified an issue with staff recognising the need to assess and fully document consent and mental capacity.

Evidence based care and treatment

- Community services used guidance from NICE and the Royal College of Nursing. We saw references to and use of national guidelines within a number of services, such as pressure ulcer and falls prevention. Policies and best practice guidelines were used to support the care and treatment provided for patients. Specific pathways and guidance were used for certain long-term conditions; staff accessed this information on the trust intranet and through monthly updates in the Care newsletter which were supported by training.
- We found that staff understood their roles and responsibilities in delivering evidence-based care. Staff used nationally recognised assessment tools to screen patients for certain risks and they referred to relevant codes of practice, for example those on infection control guidelines.
- Patients' assessments were completed using templates available on the trust's computer system; these followed national guidelines for measuring harm. For example, a multidisciplinary falls risk assessment tool followed NICE recommendations for the assessment and prevention of falls in older people. We observed staff administering care to patients in the specialist falls service and saw that evidence based practice was followed correctly.
- A community matron in neurological conditions within the service was a member of the guideline development group for NICE.
- Patient Group Directions (PGDs) were used in community services based on national guidance for treatments. We reviewed several PGDs used in the service. For example a PGD was in place for the administration of certain vaccines. Community nursing staff in a focus group confirmed this. Another example was the community emergency response to male acute painful retention of urine to prevent unplanned admission.
- The clinical audit programme for the service including internal audit supported and monitored the implementation of NICE guidance. A review of compliance with NICE guidelines was included in the clinical audit work programme for 2015-16.
- Local audits in Doncaster community integrated services were used to support the wider audit programme for the trust. We saw, for example, that the compliance with wound care audit achieved a good outcome for the service.

Good

Are services effective?

Pain relief (always include for EoLC and inpatients, include for others if applicable)

- Community services supported the review of patients with pain symptoms and used a recognised evidence based pain assessment score.
- We observed a member of nursing staff attending seven patients that required pain relief as part of their care. The patient's pain was re-assessed for each patient as appropriate and the outcome documented; the pain was re-evaluated following the nurse's intervention.
- We found that pain levels were recorded in the care plan linked to the wound care that the patient received. For post-operative pain management, a scoring system was used and recorded in the patient's electronic record. We observed that the patient received pain medication appropriately. We found the patient was contacted by phone ahead of a nursing visit so they knew to take their pain relief.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- In the Patient Led Assessment of the Care Environment (PLACE) survey 2015 the trust achieved below national average for food; 87.5% as against a national average of 88.5%. However, the trust improved significantly from its 2014 result which was 74%.
- Patients received a nutritional assessment as part of the first assessment undertaken by the service. This used a recognised nutritional assessment tool. When we observed care we saw that the nutritional assessments were completed and recorded correctly.
- Community nursing staff could refer the patient to a dietician if this was required. The patient's GP was notified of this through the electronic patient record system.
- For one patient we observed, we saw that their nutritional score was zero, indicating low risk, although the patient received monthly monitoring and their care plan record indicated a poor diet and that a request to the patient's GP for fortified drinks had been submitted. We discussed this with nursing staff at the time of our inspection.

Technology and telemedicine (always include for Adults and CYP, include for others if applicable)

- Community nursing had developed a tele health service to support the delivery of effective care and treatment to patients. The service was patient led and accepted direct referrals from patients, as well as referrals from health professionals. For selected patients, for example, following discharge after cardiac surgery, the service undertook the weekday remote monitoring of their vital signs. Patients were supported to achieve self-management of their condition, usually using a self-management plan.
- The tele health service worked to recognised guidelines for telemedicine. The tele health service also supported and worked in conjunction with specialist nursing staff. For example, patients who had received a lung transplant were monitored remotely to support the visits of respiratory nursing staff. We saw similar examples for cardiac patients.
- The service used a small team of qualified nursing staff (Band five) representing a range of skills to deliver its tele health service. Staff had received specialist training for their role, for example, in motivational interviewing.
- An external organisation supplied and maintained the specialist equipment which the patient used for their telemedicine. A technician from the organisation undertook a visit to the patient to support their understanding of its use.
- The tele health service sought patient feedback through your opinion counts and had undertaken a number of case studies to demonstrate its effectiveness. The service had significantly reduced visits undertaken by the cardiac service. For COPD patients, tele health monitoring significantly reduced the patient's frequency of admissions to hospital.

Patient outcomes

- The service participated in the National Intermediate Care Audit in 2015. The service achieved 75% or above on most standards in the 2014 results. The results for eight out of 10 standards had improved from the 2013 results. The two that had not improved were related to mandatory training. The audit lead had completed an action plan with a timescale. During our inspection we

saw evidence of the service working towards the action plan. This included introducing dependency tools and informing patients of support that was available on discharge.

- The clinical audit programme for the service included internal audit. Local audits in Doncaster community integrated services were used to support the wider audit programme for the trust. For example in an audit of medical devices used against medical policy, Doncaster community integrated services achieved 72% compliance in the 2015 audit, as compared with 51% in 2013. In a further example, the wound care audit achieved a good outcome for the service.
- The community stroke team participated in the national stroke audit. In respiratory services, staff told us that audits were linked to gap analysis to provide support for individual patients that fell between pathways of care.
- Standard outcome measures were used in the service. For example, in stroke rehabilitation, a standard ("Barthel") index was used. In the specialist falls service, "Tinetti and Berg" standard outcome measures were used.
- In a focus group, specialist nursing staff gave examples of patient outcomes which were used for their service. We reviewed an example of the 15 steps challenge for community services. This was being developed as a recognised outcome measure to provide comparative information for the service. MS specialist nursing staff told us about work undertaken with the Multiple Sclerosis Trust on developing patient satisfaction reviews to provide benchmarks across services. This was to inform work with commissioners about a new pathway of care to improve management of relapses.
- The NHS Safety Thermometer was completed monthly for community integrated services. The service reported 157 falls with harm, 235 new pressure ulcers and six catheter and new CUTIs between June 2014 and June 2015. Falls have varied widely month to month, for example just one occurred in November 2014 but 20 in April 2015.

Competent staff

- Community service staff were supported with a range of training opportunities to develop their skills. The service shared a number of examples of training events that had been held in the previous 12 months.
- Community and specialist nursing staff received annual appraisals and staff development, although appraisal data received from the trust was incomplete. Evidence submitted for community integrated services showed the rate of completed appraisals covering a wide range. For example, the diabetes team showed that 66% of appraisals were complete, but in a number of other teams 100% of appraisals were completed. Most staff we spoke with had received their appraisal in the previous 12 months, or it was arranged. One area nursing team we found was an exception to this.
- Staff were encouraged to select a clinical supervisor apart from their line manager, from a list of available clinical supervisors. We found several examples where this had worked well for the member of staff concerned. However, we identified concerns in some parts of the service that staff did not always receive appropriate and consistent clinical supervision. We found there was inconsistency across different professions in the service as to the duration and frequency of supervision that staff received. We found that nursing staff did not receive clinical supervision within their team. For some specialist staff, clinical supervision was provided by a consultant in their specialism. This may be done informally.
- Within the community integrated service, each area team included a clinical practice educator (Band 7) to support upskilling and staff development. Qualified and non-qualified nursing staff received an induction which was supplemented by a programme provided by the clinical practice educator. Shadowing was also used both formally and informally. The clinical practice educator's remit included mentoring. Student nursing staff in a focus group spoke appreciatively of the support they received from mentors and the organisation.
- Nursing staff attended an individual one to one meeting with their line manager. Usually this was arranged three times a year.

Good

Are services effective?

- Community nursing staff in a focus group told us the trust was supportive of their learning and provided good training opportunities. Some nursing staff had completed a preceptorship. Specialist nursing staff in a focus group gave examples of where they were involved in developing and delivering training. Some staff had received further training to enable them to facilitate groups of patients.
- Qualified nursing staff were supported to maintain their registration. We found staff were contacted by email to ensure they were aware of revalidation requirements.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary working was well developed in community integrated services. Social services was co-located with the community nursing teams so that health and social care staff supporting the same person in the community could easily have informal contact, particularly involving community matrons for more complex patients.
- A weekly MDT meeting ("One team meeting") was held in community integrated services, which was minuted. The regular pattern was for the care and treatment of patients to be reviewed over a cycle of three to four weeks. Staff we spoke with said working relationships within the MDT were effective and gave examples of this. Nursing staff could refer patients directly to physiotherapists, without the need to go through an MDT meeting. The MDT meeting helped to maintain formal and informal contact with GP's although they did not currently attend the meeting in person. When we observed visits in the community, we saw that letters were generated and sent to the patient's GP relating to that day's visit.
- Specialist services were managed within community integrated services. Occupational therapy (OT) staff were co-located in three areas corresponding with the social care teams. OT supported continuing health care panels. Centrally located teams included dieticians and podiatry, contributed to the MDT meeting. Physiotherapists based in the local acute trust worked in an integrated way in contributing to the team.
- Community specialist staff in a focus group for staff in the neurological rehabilitation multidisciplinary team explained how they supported patients using an integrated, multi-disciplinary approach supported by links with consultant, community nursing and social services staff. New referrals to the stroke rehabilitation service were allocated and managed at the multi-disciplinary meeting; we saw there was a good rapport between the community team and the stroke consultants with whom they regularly liaised. Multi-disciplinary teams working with an integrated approach helped with a prompt access response for patients.
- Staff said they could easily access mental health services for their patients, because the services were also part of the same organisation. Mental health crisis calls were to be received by the single point of access centre from September 2015
- Community integrated services maintained effective links with the MDT in the local acute trust. Service leads, with social care and acute trust representatives, attended a strategic forum and managers from the service and the acute trust attended an operational forum, both held monthly.

Referral, transfer, discharge and transition

- The Doncaster single point access (SPA) provided clinical triage and assessment for patients requiring community nursing services. Patients were referred from a range of health and social care contacts and may self-refer. Community nursing received referrals for patients who were discharged from hospital who may still be under the care of the hospital. Referrals were prioritised and were assessed and clinically triaged by qualified nursing staff. The triage nurse decided the most suitable service to meet the patient's needs. Referrals which were assessed as not requiring input from services were signposted to another team or agency.
- We observed and listened to seven calls which arrived in the SPA. We were told the triage nurse made clinical decisions as to when a patient ringing through to the system would be seen. Patients with a long term condition, who were routinely visited by the planned care team district nurses and phoned through for an unplanned visit, would initially be seen by nurses from the unplanned care team. The planned care team would then take over and continue to see the patient. Staff told us they had a good relationship with the community planned care services and at busy times they helped each other out.

Good

Are services effective?

- Specialist staff in a focus group explained that specialist services followed defined and agreed referral criteria. For example, the respiratory nursing team accepted referrals for patients with severe COPD and a confirmed respiratory diagnosis, with a risk of admission or readmission to hospital. Patients could not self refer to therapy services; PD specialist nurses received referrals from consultants following the patient's diagnosis, for example, following a fall. For patients with pressure ulcers, a referral to the nursing service or a GP may be referred to a tissue viability nurse. The tissue viability and lymphedema service were able to make onward referrals to other services such as podiatry and oncology. The neurological rehabilitation service told us that 50% of referrals were from consultants and patients could self refer to the service. Patients could self refer to the continence service.
- Following a patient's discharge, the diabetes specialist nursing service phoned the patient, completed a questionnaire and give immediate advice. The information was forwarded to the patient's GP and they were allocated an appointment with their local diabetes nurse. When patients were discharged from the respiratory specialist service, it was with the understanding that they could come back at any stage. Patients were discharged from the specialist falls service after 12 weeks, but could subsequently self-refer, although the service had very few self referrals. Community nurses occasionally attended discharge planning meetings on wards if needed for complex patients.
- During a visit with nursing staff, we observed that the patient's relative was cutting the patient's toenails despite them being diabetic. The nurse did not discuss referring the patient to the podiatry service. We discussed this with staff during our visit.

Access to information

- Information was available through the trust intranet to support staff and access was provided to external internet sites.
- Community services used an electronic patient record system widely used in the NHS and live information about patient care and treatment was available. Within the trust patient records were held using two different clinical computer systems. A clinical systems review was being undertaken to address this. Additionally, not all GPs allowed access to information on their systems. The trust communicated with staff in the service about information and technology developments which affected them through a trust information and technology newsletter ("Connect").
- We saw that community services published a newsletter for GP's ("GP News") to keep primary care practices informed about service developments and other matters affecting patients. The service had developed other newsletters aimed at informing particular patient groups, for example, for patients with multiple sclerosis, and a newsletter for patients who used the neurological rehabilitation service.
- Staff received a monthly corporate newsletter ("Trust Matters") via e-mail. Staff were encouraged to submit articles for this publication. Staff also received feedback through information sent out with their payslips, for example a safeguarding leaflet. The Learning Matters newsletter captured lessons from across the trust, including examples of excellent practice and areas for improvement following serious incidents or complaints.
- Community services staff received a daily email from the trust's communications team with the latest news and update information to support them in their role. For example, during our inspection we saw an update staff received was about the publication of an updated British National Formula (BNF) with advice on prescribing and pharmacology, linked with useful facts about medicines. The chief executive sent out a weekly email to all staff.
- Information was disseminated to community nursing staff at monthly cluster meetings. Community specialist nursing staff in a focus group told us that managers were effective at using team meetings to keep staff abreast of changes and allocated time to discuss progress and any issues encountered. Daily communications from the trust and the chief executive blog were seen as positive.
- Some specialist services were setting up websites to provide information about their service for staff and patients. For example, the respiratory service were including a video to show patients how to use an inhaler.

Good

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Deprivation of Liberty Safeguards provide a legal framework to ensure that patients are only deprived of their liberty when there is no other way to care for them or safely provide treatment and to ensure that patient's human rights are protected.
- Staff demonstrated an understanding of consent, MCA and decision making. Patients who used community integrated services were asked to give consent appropriately and correctly. Verbal consent was obtained before care was delivered. We reviewed consent information for a selection of patients as part of our review of records and found that with two exceptions it was obtained and completed correctly.
- Staff told us a care plan was agreed with the patient who received care and a copy was printed. The copy was signed by the patient and then scanned into their records as an electronic copy. Staff said that if a patient refused care a refusal of care form was completed and in a similar way the person would be asked to sign it and it was scanned onto their electronic records.
- The Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) were included in mandatory training. Data submitted by the trust showed between 93.3-100% compliance with MCA and DoLS training.
- When we accompanied staff during visits to patients, on two occasions we identified an issue with staff recognising the need to assess and fully document consent and mental capacity. This was discussed with the service during our inspection.

Good

Are services caring?

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

Summary

Patients and relatives were treated with respect, dignity and compassion. Staff demonstrated a good understanding and were very reassuring to patients. Confidentiality was maintained in discussions with patients and their relatives and in written records or other communications. Patients spoke very positively and expressed their appreciation as to the quality of care they received.

Staff offered clear explanations and checked the patient's understanding. Regular clinics were held by some specialist community services for patients who were able to visit a community location. Patients were empowered to engage in self-care.

Staff provided emotional support to patients and their relatives and carers. Staff demonstrated the emotional aspects of care for patients living with long-term conditions.

Compassionate care

- The service scored better than the national average in the Patient Reported Experience Measures (PREMS) section of the 2014 National Intermediate Care Audit. This included questions about patients' experience of being treated with dignity and respect.
- During our observation of care we saw that patients and relatives were treated with respect, dignity and compassion. Staff demonstrated a good understanding and were very reassuring to patients, their relatives and other people. Staff were sensitive in the way they discussed the patient's weight with them. We observed an example of consideration for a patient when a patient visited the diabetes service to see the dietician. Staff checked if the patient could be seen at that time to prevent them needing another appointment requiring a return journey.
- Staff respected patient confidentiality when delivering care and treatment. Confidentiality was maintained in discussions with patients and their relatives and in written records or other communications. We observed specialist nursing staff in a clinic setting. Patients who attended the clinic were informed that they should ask for the nurse by name when they arrived at the clinic. This protected the patient's privacy and dignity as they did not need to mention they had an appointment at the clinic.
- We observed the interaction of nursing staff in their telephone interaction with six patients. We found the conversations were appropriately respectful and sensitively handled. Staff demonstrated a caring and compassionate attitude in their interaction with patients.
- Patients spoke very positively and expressed their appreciation as to the quality of care they received.
- In a small number of instances where we observed single handed care being delivered by qualified nurses of Band five level, we found that aspects of their approach may have had an adverse impact on the care delivered to the patient, particularly related to wound care. This was discussed with senior staff during our inspection.

Understanding and involvement of patients and those close to them

- We observed that staff demonstrated good communication skills when they examined patients. Staff offered clear explanations as they checked the patient's understanding. Staff were knowledgeable as to the patient's symptoms and related their injury or condition to the patient's occupational and functional needs.
- Staff explained to the patient what they could expect to happen next and gave details of likely and possible outcomes by answering questions from the patient directly. Staff arranged further visits if more information was required to support the patient with their care and treatment.
- Regular clinics were held by some specialist community services for patients who were able to visit a community location. The clinic setting provided an additional opportunity for staff to support the patient's understanding of their condition and for the patient to exchange useful information with other patients and carers. For example, the Doncaster Type Two

Information Education (DOTTIE) group supported patients with diabetes. The respiratory team ran breatheasy sessions. The tissue viability service supported a lymphedema support group which was run by patients. A further example was the balance exercise group run by the falls service with the objective of empowering patients and teaching self-management.

- A range of information for patients and carers was available in booklet form for staff to use during home visits and in clinic settings.
- During one visit where we observed single handed care being delivered by a qualified nurse (Band five), to a patient with complex needs, we found that interaction with the patient's relative was very limited, with no supportive discussions seen. However, the patient and their relative both stated they were happy with the service they received.

Emotional support

- We observed that staff provided emotional support to patients and their relatives and carers as they delivered care and treatment. Staff demonstrated they were aware of the emotional aspects of care for patients living with long-term conditions. They provided additional support for patients and their carers where this was needed.
- When we accompanied staff making home visits, we observed that staff were sensitive to emotional issues. We observed as a specialist nurse provided support to a patient's family members to help them come to terms with deterioration in the patient's health. Patients and relatives expressed their appreciation of the emotional support they received, including with their mental health needs. They particularly appreciated that the member of staff talked frankly about the future and was very clear that there were actions they could take to alleviate the patient's condition. Staff also gave current and recent examples which provided patients and their relatives with emotional support in response to their immediate needs.
- Community nursing staff in a focus group explained how they worked with patients to set patient centred goals to help the patient understand what they hoped to achieve during their engagement with the service. Patients were encouraged to set their own goals. Staff shared booklets with the patient to complete with their family when for example, the patient had suffered a loss of independence and additional emotional support was required.

Good

Are services responsive to people's needs?

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

Summary

Services were planned and delivered to meet the needs of patients appropriately, particularly those with complex conditions. The service engaged with hard-to-reach groups. The needs of bariatric patients were addressed. The service addressed the diverse needs of the traveller community.

The service made speedy and timely interventions; patients were assessed promptly and referral to treatment times consistently exceeded the 18 week target. Mental health services were accessible and joint visits could be arranged with community nursing staff. The needs of minority ethnic patients were reflected in service provision, for example by the use of the interpreter policy. Although there were few complaints learning from the investigation of complaints was shared with staff.

The service was reviewing access to community services for patients with a learning disability. The needs of patients with dementia were not always considered appropriately.

Planning and delivering services which meet people's needs

- During 2015 the trust introduced a revised structure for community services. The service worked with commissioners, the neighbouring acute trust, social services and other stakeholders in two Doncaster wide reviews of intermediate care and neurology services which considered the holistic patient pathway. Community nursing was redesigned to follow a case management approach within a local team structure. Doncaster integrated community services was one of seven business divisions within the trust. Integrated community services operated in separate planned and unplanned care teams. Patients were seen initially by staff from the unplanned care team. The planned care team then took over the patient's ongoing care. Unplanned care was centrally located and included the out of hours service.
- From June 2015 case management commenced as part of the redesigned service. Integrated community services operated in four area teams, Central, North West, North East, and South, within a "One Team Working" overall boundary for Doncaster. A single point of access provided clinical triage and assessment for incoming referrals to the service. The service used clear admission criteria and referral pathways for access to the range of nursing and specialist services within integrated community services.
- Moving into integrated teams was seen as positive by staff. They felt there were better outcomes for patients using the revised service; housebound patients received a better service now that staff were utilised differently. Community nursing staff had moved to case management which had improved the service patients received; they now received holistic care. Although the case management approach was still to become embedded, nursing staff in a focus group felt there was better communication between the planned and unplanned teams.
- Some specialist services worked to the same one team boundary. For example, the continence service deployed specialist staff in clusters aligned with the four one team working areas. Occupational therapists were co-located with three of the five one-team-working areas. Podiatry was a stand-alone service; dieticians were centrally located. The physiotherapist service was based in the neighbouring acute trust.
- The community rehabilitation service included the neurological rehabilitation outreach team as well as the stroke team, multiple sclerosis nurses, Parkinson's nurses, the specialist falls service, wheelchair and specialist seating service, dietetics, speech and language therapy and occupational therapy. Each of these teams had access to therapy services.

Equality and diversity

- Community services recorded the diversity aspects of the patient's needs at their initial assessment.
- Community services used a current interpreters policy, as available trust wide, which we found staff were aware of and were able to give examples of the circumstances in which they had used the policy to help with access to services for patients and carers. Interpreters were available for British Sign Language. Staff told us they had encountered no problems with the interpreter service.

Good

Are services responsive to people's needs?

- We observed staff communicating with a patient from a minority ethnic community. When we spoke with the patient about the service they had received, they told us the staff were sensitive to their needs and treated them with respect. They said the staff were welcoming, easy to talk with and they would recommend the service.
- The service provided care and treatment and engaged effectively with patients from the traveller's community.
- Community services had developed a range of information for patients and carers which was available in languages other than English, large print, braille and audio tape. Staff in a focus group told us the service had 24 hour access to support groups for the needs of different religious groups.
- We found examples in the service of communication with hard-to-reach groups in the Doncaster area. The diabetes specialist service liaised with social workers and GP's as needed where people needed access to mental health services for treatment as well as extra care and treatment or advice. They directed patients to food banks, and other sources of free meals.
- Community specialist nurses in a focus group told us they screened new entrants to the service who had recently arrived in the UK for latent tuberculosis (TB). Staff visited locations they had identified where people who had recently arrived from overseas met and visited there to carry out screening. For example in June 2015 the service screened 19 people, eight of whom had TB and seven of whom tested positive.
- Information supplied by the trust showed that in July 2015, 68% of staff had completed mandatory training in equality and diversity, compared with a trust target of 90%.

Meeting the needs of people in vulnerable circumstances

- Caseloads for community nursing teams included patients with a learning disability. Staff in nursing and specialist services that we spoke with could arrange additional support for patients with a learning disability when this was required. The neurological rehabilitation service provided support for patients with a learning disability. The service was working jointly with commissioners and social services to review access to community services for patients with a learning disability.
- Mental health services were accessible as they were part of the same trust, and joint visits could be arranged with community nursing staff. The mental health crisis hub was included in the community single point of access from September 2015. A patient's mental health needs were reviewed as part of their initial assessment. Community nursing services would arrange to visit with another member of nursing staff where a patient was identified with mental health or behavioural needs. The neurological rehabilitation service provided support for patients with a need to access mental health services.
- The trust's Learning Disability business division had been involved in developing a new and overarching dementia care pathway for learning disability services. The pathway was approved by the learning disability clinical governance group. Arrangements were in place for staff to attend dementia awareness training. Nominated members of staff were identified as dementia friends. The needs of patients with dementia were recorded in the electronic patient record. When we accompanied nursing staff on visits to patients with dementia, we found nurses were not always considering referrals to support services for example, assessment of mental health or cognition.
- We found the needs of bariatric patients were addressed. In the falls service, staff had received recent training in the use of bariatric equipment. The tissue viability and lymphedema service was due to install a new bariatric plinth in one of the treatment rooms and training was to be provided for the staff by the organisation supplying the equipment. In another instance community nursesarranged to visit the patient with an occupational therapist, a physiotherapist, a dietician and other nurses to support carers. An MDT meeting was held to ensure the patient received the care they needed. However, on one visit we observed the member of nursing staff was unaware of the need for another staff member to assist with moving and handling and the visit needed to be rearranged.

Good

Are services responsive to people's needs?

Access to the right care at the right time

- Quality indicators for community services showed that patients were assessed promptly for care and treatment, and that this was consistently within the expectations of patients and commissioners. We reviewed the clinical commissioning group's quality and performance report for July 2015 which showed that referral to treatment times (RTT) for community services met the 18 week targets and in most instances was recorded as achieving 100%. For a range of services, patients did not have to wait to gain access. There were some exceptions identified; these were individually reviewed on a monthly basis and where they were found to be legitimate, it was identified the "true" compliance rate was above the trust target.
- Managers were aware of some inaccuracies in the performance dashboard data and were working with commissioners to resolve these.
- The monitoring information which showed that minimal waits for services were maintained was confirmed when we visited community locations and spoke with staff and patients. Patients commented on their ease of access to the service.
- Within expected referral to treatment times, services responded to patient referrals according to the urgency of the patient's needs. For example, in community nursing, we found emergency referrals were responded to within two hours and urgent referrals within four hours. We were informed there was no waiting list for the community nursing service. However, there was no data available to demonstrate this was fully monitored.
- There were separate waiting lists for each specialist service and waiting times were monitored and managed within the service. For example, wheelchair services planned to reduce waiting times to zero in March because the demand for wheelchair services increased in the summer months. We were informed that at the time of our inspection waiting times for speech and language therapy were nine weeks. The stroke team acknowledged referrals within two days and responded within 10 days. Occupational therapists and physiotherapists responded within three weeks. There was currently a longer wait for physiotherapy of five weeks which the service was working to resolve. In the tissue viability and lymphedema service, urgent referrals were seen within five days and non-urgent referrals within 15 days. The stroke rehabilitation team had a waiting time of almost five weeks. We were informed that audits were conducted to ensure that these referral to treatment indicators were not being breached; the targets were usually met although we did not see any evidence of this.
- Doncaster community integrated services moved to a single point of access for the service during 2015 We observed and listened to seven calls. We noted the calls were answered within seconds. The caller received a call handler welcome message after 11 seconds and a further progress message if they queued. We saw the call wait was two to three minutes. The call handlers were skilled in their roles as they answered the calls in a timely way. Calls were logged, including the time the person was waiting to speak with a call handler. This was displayed on a large screen which the lead officer monitored. We were informed by senior staff that audits were undertaken but the results of these were not available as the service was working with commissioners to agree response timings.

Learning from complaints and concerns

- Information submitted by the trust showed the service received 24 formal complaints between November 2013 and April 2015, nine of which were upheld. These represented a range of themes across all teams.
- Although there were few complaints learning from the investigation of complaints was shared with staff and they were able to give examples where improvements had been identified. The outcome of the complaint investigation was shared with the patient and an action plan was prepared when complaints were upheld.
- The Learning Matters newsletter available on the staff intranet captured lessons from across the trust, including examples of practice and areas for improvement following the investigation of complaints. Learning from the investigation of complaints was discussed with staff at monthly meetings.
- Staff were aware of the procedure to follow for complaints and there was a complaints leaflet staff could give to the patient should they wish to complain.
- A separate Patient Advice and Liaison Service (PALS) leaflet ("We're here to help") was available for patients

Good

Are services responsive to people's needs?

and information about complaints was available on the trust's website. A "Your Opinion Counts" leaflet included information about PALS and formal complaints and was available in different languages, Braille, audio, large print and electronic versions.

- In the community locations we visited we observed there were notices displayed which advised patients and relatives about how to make a complaint and provide feedback about the service.

Good

Are services well-led?

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

Summary

The leadership of the service, following recent restructuring, was joined up with the executive leadership. Staff knew the trust's vision and values and strategic objectives were in development at service level. A risk register was in place for the service and reflected known risks. Regular governance meetings were held and senior staff shared information from the governance meetings through team meetings.

Managers and staff felt supported by the trust and the service reflected an open and honest culture. Staff engagement sessions were held to seek staff opinions. We found a range of examples of innovative practice and some examples of outstanding practice in the service.

For specialist services, clinical supervision was undertaken by qualified staff but we identified some shortcomings in the supervision of Band 5 nurses' caseloads

Service vision and strategy

- A five year strategic plan was in place for the business division. The plan included an options appraisal and considered priorities and risks. There was limited documentary evidence of how this was linked to trust's strategic objectives, although staff we spoke with knew what these were.
- The executive management team explained the trust's strategy to us. The service's initial focus was on the clinical commissioning group's (CCG) reviews of intermediate care and neurology services across Doncaster. The executive told us the service had an opportunity to review strategic objectives as part of annual planning with the objective of continuously reviewing services and investing in the workforce.
- Managers at service level told us they felt the overall vision was clear but their teams were at different places in developing their strategic objectives, linked to new service specifications. Managers were working with each team to support the corporate vision and move the service forward. Managers told us the service redesign had recently provided the focus and they needed time to look at the vision for the future. This would be done monthly and involve staff in the service.

Governance, risk management and quality measurement

- The trust had a risk management strategy for 2013-16 which linked with the corporate risk register for the trust and key governance arrangements, for example, the risk management sub group, the clinical governance group and the clinical effectiveness group.
- A risk register was in place for Doncaster community integrated services which reflected known risks. All risks entered on the trust risk management system were assigned a current risk rating; for example the difficulties encountered in recruiting and retaining qualified nurses in community services was reflected as a high risk. Controls in place and actions to mitigate the risk were identified and monthly updates were recorded.
- The clinical effectiveness group was responsible for oversight of the clinical audit programme and to ensure action was taken in response to the results of clinical audit and the recommendations of external reports. We found that audits undertaken in Doncaster community integrated services were part of the trust audit programme, for example clinical records. In addition some local clinical audits were undertaken.
- The service held regular governance meetings, for example a clinical and quality assurance meeting. Within the local and specialist teams, meetings linked to a senior nurse meeting and a monthly service cluster meeting. Each team leader held a regular meeting with their staff; some team meetings were multi-disciplinary and were held weekly, monthly or bi-monthly. A set agenda was used for team meetings and included practice guidance and learning from the investigation of incidents and complaints; staff were invited to add items. We saw that some service areas structured the team meeting agenda according to CQC's five key questions. The Doncaster community stroke

rehabilitation team meeting used a multi-disciplinary structure and included a review of service KPI's and waiting lists. Senior staff shared information from the governance meetings through team meetings. Staff felt the regular team meetings provided important peer support.

- The service maintained current governance and performance information on the trust's computer system which included audit action plans and meeting minutes.
- For specialist services, clinical supervision was undertaken by qualified staff within the team and the team leader checked clinical and management supervision during one-to-one meetings with staff. We identified some shortcomings in the supervision of Band 5 nurses' caseloads. For example, we found some occasions when the Band five nurse did not realise the clinical risk management needed and did not escalate to a Band six member of staff. This was attributable to a lack of overview by a more senior member of nursing staff. This may put patient at risk of receiving lower levels of clinical assessment.

Leadership of this service

- We found managers felt supported by the trust. Staff knew who the executive team were. Non-executive directors and the director of nursing had visited the service. Senior staff felt the business division was well represented at executive level which included attending the weekly directorate management meetings. The divisional director was seen as a motivational leader.
- Community nursing staff in a focus group told us the new chief executive was visible and proactive and visited services when she started. The chief executive was active in coming back with an answer. Staff received feedback through a weekly newsletter which appeared to welcome feedback and they received regular emails from the chief executive which always said thank you for hard work, especially out of hours and weekend staff.
- Staff told us they felt senior staff and managers were visible, approachable and supportive. Service managers undertook weekly walk rounds and attended different team meetings. They listened to staff ideas.
- Senior staff had attended the trust's leadership training "fit for the future" and spoke positively of this training. Therapists received support from their professional leads as well as line managers.

Culture within this service

- Staff said they enjoyed working for the trust and being part of their team. They were proud to work in the trust and felt part of the team they worked in. Staff conveyed to us they were part of an open and honest culture. Staff in a focus group told us they worked well as a team and any problems got sorted out quickly.
- Staff told us they felt supported to report incidents and raise concerns to their line managers. Managers sought their views when implementing change. They said their manager was approachable and they could have a meeting with them at any time. They also told us the manager thanked staff for their work. They did not feel under pressure from managers to work additional shifts or types of shift patterns even during periods of staff shortages.
- Senior staff told us trust policies were relevant to physical health as well as mental health.

Public engagement

- Staff encouraged patients to complete the Your Opinion Counts patient satisfaction survey to help improve the service. The your opinion counts postcard was given to the patient on discharge.
- The trust participated in a "Tweet us" campaign; community locations displayed the information and patients received a response on Monday to Friday between 9am and 5pm.
- Community specialist nursing staff in a focus group told us about their use of the 15 steps challenge toolkit which was designed to improve quality of services by patient, carers and the public. The 15 steps challenge for community services was being applied for staff visiting patients at home. We reviewed an example which the wheelchair and special seating service completed in 2014 and we saw an action plan was prepared.
- The specialist falls service asked patients to complete a "20 second feedback" proforma and we saw the analysed results for 2015. The multiple sclerosis

specialist nurse service carried out a patient experience survey in 2015 as part of a UK-wide programme to evaluate and improve MS specialist services and reported the results in September 2015.

- Community locations displayed thank you cards giving patient and carer feedback. We reviewed letters of appreciation from patients which without exception made positive comments. We saw an analysis of 580 written compliments the business division had received between April 2014 and September 2015.
- We were informed that the neuro outreach team planned to hold a patient engagement event in October 2015.
- The stroke rehabilitation service team was involved with the local acute trust in a pilot of a stroke pathway patient survey that commenced in April 2015. At our inspection results were awaited from the pilot survey.

Staff engagement

- Staff we spoke with felt that communication within the trust and their service was good. Community nursing staff in a focus group told us they received feedback through a weekly newsletter which appeared to welcome feedback and they received regular emails from the chief executive.
- Staff received "Trust Matters" monthly by email and teams were encouraged to submit articles for this publication. The trust also issued a monthly staff bulletin ("Team Talk") which invited feedback from staff. The trust issued frequent short briefing documents to staff to provide updates on key changes and developments in the service and to consult and engage with staff. This was supported by facilitated "time out" sessions where staff were informed and consulted on key changes in the service.
- Formal staff engagement sessions were held to seek staff opinions during the recent restructuring of community services. Specialist nursing staff in a focus group told us of their experience with the recent service redesign. Service leads gave examples of how they were working with commissioners; staff felt very involved and were kept updated by their service managers. The service was undertaking a review of how staff engagement implementation had gone which was due to report in October 2015.

Innovation, improvement and sustainability

- DCIS were included in a trust scheme "RDaSH Awards" to reward staff innovation and achievement. We saw the agenda for this year's awards, which took place in September 2015. A team leader had won a "Clinician of the year' award for success in improving services through planned and unplanned caseload management. The service achieved "Clinical Team of the Year" for the community nursing service transformation.
- Specialist teams were particularly effective and some specialist services were outstanding. In respiratory services, for example, multiple pathologies were identified and patients with long term conditions (as COPD) were supported to attend Breatheasy sessions. The respiratory specialist service had an innovative system for managing oxygen intolerance.
- The specialist falls service facilitated the falls and balance group for patients attending a 12 week balance programme. We reviewed positive patient feedback about the programme.
- The dietetics service used the MUST tool innovatively to support community nurses offering "Food First" advice.
- Speech and language therapy introduced phone triage for patients experiencing significant difficulties swallowing. The caller was checked for symptoms of dysphagia (difficulty swallowing).
- The neuro rehab outreach team supported a self-management group ("SELF") for patients with long term conditions. We saw evidence of patient involvement in the development of the group.
- The stroke rehabilitation service worked in partnership with the local acute trust in developing a pilot early supported discharge pathway for stroke patients. At our inspection results were awaited from the pilot survey.
- The tele health service within DCIS was patient led and accepted direct referrals from patients, as well as referrals from health professionals. For selected patients following discharge the service undertook remote monitoring to help the patient achieve self-management of their condition. The tele health service sought patient feedback through Your Opinion Counts and had undertaken a number of case studies to demonstrate its effectiveness. The service had

Good

Are services well-led?

significantly reduced visits undertaken by the cardiac service. For COPD patients, tele health monitoring significantly reduced the patient's frequency of admissions to hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed within the community nursing teams. Regulation 18 (1)