

Sandwell and West Birmingham Hospitals NHS Trust

RXK10

Community health services for adults

Quality Report

Rowley Regis Hospital, Moor Lane, Rowley Regis

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This report describes our judgement of the quality of care provided within this core service by Sandwell and West Birmingham Hospitals NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Sandwell and West Birmingham Hospitals NHS Trust and these are brought together to inform our overall judgement of Sandwell and West Birmingham Hospitals NHS Trust

Summary of findings

Ratings

Overall rating for Community health services for adults

Good



Are Community health services for adults safe?

Requires Improvement



Are Community health services for adults effective?

Good



Are Community health services for adults caring?

Good



Are Community health services for adults responsive?

Good



Are Community health services for adults well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
Background to the service	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the provider say	6
Good practice	6
Areas for improvement	7

Detailed findings from this inspection

Findings by our five questions	8
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Summary of findings

Overall summary

We saw good evidence of learning from incidents, but could not be assured that it was universal.

At Rowley Regis Hospital we found prescription medicines that were not appropriately stored, together with out-of-date clinical equipment.

Staff were competent to carry out their role, and identified and responded to patient risk in a way that ensured patient safety. There were vacancies across the service, which meant caseloads were increased for some nursing and therapy teams. Staff told us that they were happy to come to work, and spoke positively of the contribution they made to patient care.

The service was effective and caring. Care and treatment was evidence-based, and staff followed current best practice recommendations. There were positive examples of multidisciplinary working across internal services, and between local healthcare organisations. All patients and carers spoke positively about the care provided, and we observed staff delivering compassionate care.

The service was responsive to patient need, and patients were treated in their own homes or community clinics where possible. Services engaged with patients to gain feedback and improve service provision.

Many services had practices in place to prevent unnecessary hospital admissions. An example of this was the integrated care services (iCARES), an open access integrated care service that managed adults with long-term conditions.

Staff felt that hospital services and senior managers did not understand the role of community services, and many staff felt that community services were the 'poor relation' compared to acute services.

There were notable examples of innovation; these included the community alcohol service that had integrated into the trust, and the Cape Hill district nursing team, who participated in an 'Aspiring to Clinical Excellence' project. The service promoted clinical audits, projects and research pilots.

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The service was effective and caring. Care and treatment was evidence-based, and staff followed current best practice recommendations. There were positive examples of multidisciplinary working across internal services, and between local healthcare organisations. All patients and carers spoke positively about the care provided, and we observed staff delivering compassionate care.

The service was responsive to patient need, and patients were treated in their own homes or community clinics where possible. Services engaged with patients to gain feedback and improve service provision.

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Summary of findings

Background to the service

Sandwell and West Birmingham Hospitals NHS Trust community division delivered community-based services to adults with long-term conditions, across Sandwell. The area included a large urban conurbation, with high levels of deprivation, as well as pockets of relative affluence. The community and therapies group provided a range of health services, including district nursing, integrated care and therapy.

The service had well embedded partnership working with patients, across trust services and other local healthcare organisations. Care was delivered in a range of locations, including patients' own homes, community hospitals, and community-based health clinics.

During our inspection, we visited four district nursing teams at **Glebfields Health Centre, Victoria Road Medical Centre, Cape Hill Medical Centre** and **Mesty**

Croft Clinic Health Centre; and we spoke with over 20 district nurses. We visited iCARES and therapy services based at Rowley Regis Hospital and the Lyng Centre; we spoke with over 20 members of staff working within these teams. We visited a community alcohol service at the Lyng Centre, and spoke with a member of the team.

We spoke with staff, including nurses, managers, therapists, support staff, and administrative staff. We observed care and treatment, and looked at care records. We received information from our listening events, and contacted people who use the service to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust, and information from the trust.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing & Quality, Kent Community Health NHS Trust.

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team included 15 CQC inspectors, 27 specialist advisors to include: Consultants, Doctors, Matrons,

Nurses, Midwives, Therapist, Student Nurses and four 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting. The inspection team was supported by CQC analysts, planners and recorders.

Why we carried out this inspection

We inspected this core service as part of our Comprehensive wave 3 Combined Acute and Community health services inspection programme.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

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

The inspection team always looks at the following core service areas at each inspection:

Summary of findings

- Community nursing services or integrated care teams, including district nursing, community matrons and specialist nursing services:
- A range of care is provided such as long-term condition management, case management and co-ordination of care for people with complex needs or multiple conditions, wound care, medicines management and acute care provided at home.
- Intermediate care in the community:
- Usually short-term care involving a range of professionals providing symptom and condition management or more intensive rehabilitation provided after people leave hospital or following an exacerbation of symptoms, with the aim of helping to maintain independence, or avoiding the need for hospital admission or residential care.
- Community rehabilitation services:

- Rehabilitation and re-enablement following illness or injury, usually involving a range of therapists, nursing and medical staff
- Community outpatient and diagnostic services
- Prevention and health promotion services.

Before visiting, we reviewed a range of information we hold about Sandwell and West Birmingham Hospitals NHS Trust, and asked other organisations to share what they knew about the provider. We carried out an announced visit between 15, 16 and 17 October 2014. During our visit, we held focus groups with a range of staff (district nurses, matrons, health care support workers and allied health professionals). We observed how people were being cared for, and talked with carers and/or family members, and reviewed personal care or treatment records of patients.

What people who use the provider say

We spoke with 22 patients and their carers during the inspection. In addition, we contacted 12 patients who used the service. All responses were very complimentary about the staff, and the care and attention patients received.

Patients told us how kind and caring the staff were, and how well they understood their needs. Satisfaction surveys that the trust conducted were positive, and patients were encouraged to attend focus groups to provide feedback about the service.

Good practice

- There were examples of good multidisciplinary working across internal services, and with local healthcare organisations.
- Care and treatment of patients was flexible and compassionate.
- The trust promoted self-care to empower patients.
- Services were committed to delivering care as close to home as possible, and to prevent unnecessary hospital admissions.
- There were multiple services that had implemented practices to prevent unnecessary hospital admission, including the community alcohol service.
- An excellent example of innovation was iCARES, who had won a Nursing Times Award for integrated care in October 2014, and were cited as an example of good practice for crisis support at home, and in nursing homes, in the Kings Fund 2014 Developing Integrated Care report.
- The service promoted clinical audits, projects and research pilots.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- All out-of-date stock should be removed from clinical areas. The trust should put processes in place to identify and remove out-of-date stock.
- The trust should ensure that medication is stored appropriately.
- The trust should complete recruitment processes to fill vacancies across the organisation in a timely fashion.
- The trust should ensure that community staff are supplied with appropriate equipment when providing care at low levels.

Sandwell and West Birmingham Hospitals NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Requires Improvement



Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

There was a system in place to report incidents, and staff felt able to report incidents in a 'no blame' culture. We saw learning from some incidents, but lack of learning from others. Staff across community services followed the trusts infection control policy.

Safety in community services for adults with long-term conditions required improvement. At Rowley Regis day hospital we found prescription medicines that were not appropriately stored due to a high room temperature. We also found two resuscitation trolleys with intravenous fluids on, which were not locked away. We saw clinical equipment stored which had passed their use-by date.

Staff identified and responded to patient risk in an appropriate way that ensured patient safety. Staff were confident in reporting safeguarding concerns, and understood the Mental Capacity Act.

There were vacancies across the service, especially in iCARES and district nursing, which meant that caseloads were increased for some nursing and therapy teams. Staff we spoke with demonstrated robust lone working practice.

Incidents, reporting and learning

- Incidents were reported using the electronic incident reporting system. Staff told us that they were encouraged to complete incident reports, and most staff told us that they had received feedback from the reports. In the 2013 National NHS Staff Survey, 90% of staff stated that they reported errors, near misses or incidents witnessed; this was 1% better than the national average. One nurse told us that "incident reporting isn't seen as a criticism, but to put things right".
- Between February 2013 and August 2014, there had been five serious incidents requiring investigation relating to community nursing services; four were in patients' own homes, the other was in residential care/

NHS nursing home. All incidents related to category three or four pressure sores, which had been investigated to assess if they were deemed avoidable or not. Only one pressure sore had been deemed avoidable. There had been an increase in pressure sores in July and August 2014, after the inspection the trust told us that this increase had been highlighted to the tissue viability lead and risk manager to scrutinise, monitor and implement action where required to reduce incidents.

- There was learning from needle stick injuries, which averaged one to two per month. Updated guidance was circulated for district nursing teams to follow to reduce the risk of injury, and we saw this discussed at a district nurse handover. We noted that 87% of community and therapies staff had received training in inoculation incidents.
- The integrated care services (iCARES) manager told us that they encouraged staff to put action plans in place themselves as a result of an incident, to promote learning. Staff confirmed this.

Cleanliness, infection control and hygiene

- Staff followed the trusts infection control policy. Staff were 'bare below the elbow', used hand gel between patients, and used personal protect equipment (PPE). However, 45% of community and therapy staff were not compliant with mandatory infection control training.
- Where patient care was provided to people in their own homes, staff took decontaminating equipment with them, such as alcohol gel and wipes. It was recognised within the community division that there were areas where the hand hygiene audit tool was not suitable; for example district nurses told us that they had to 'double up' on visits to complete the tool, which was not effective use of resources. Instead, teams were able to contact infection control staff to discuss hand hygiene compliance.
- We spoke with 12 patients receiving home care from district nurses or iCARES, who all told us that staff always washed their hands before treating them.
- The nutrition and dietetic department had completed an annual enteral tube feeding audit of Sandwell community adult patients, to reduce infection risk and promote best practice. Improvements were found in the 2013 audit, when compared to the 2012 audit. For

example, food stored appropriately improved from 88% to 100%. However, provisions around syringes still required improvements, and there was an action plan to achieve this. A re-audit was due in November 2014.

Maintenance of environment and equipment

- Equipment was clean and functional. Items were labelled with the last service date, and some equipment had decontamination status labels that identified when equipment was cleaned.
- We found an open equipment store room at Rowley Regis Hospital. This meant that equipment, such as acupuncture needles and dressing packs, were not stored safely and securely to prevent theft, damage or misuse.
- In the store room, we found out-of-date equipment, including acupuncture needles dating back to 2000. We reported these to staff, who told us that they were unsure whose responsibility it was to check the room. The following day, we were assured that the equipment had been disposed of.
- We inspected two resuscitation trolleys at Rowley Regis Hospital, and saw that they were centrally located, clean, and defibrillators had been serviced. However, intravenous fluids stored on the trolleys were not locked away within it, and therefore not appropriately stored. We reported this to nursing staff, who contacted pharmacy to investigate.
- We saw district nurses kneeling on the floor to change patient dressings, which posed a risk of staff straining themselves during treatment. Nurses and the corporate directorate manager told us that they were trying to acquire funds to purchase lightweight stools to manage this risk.

Medicines management

- At Rowley Regis day hospital we found medicines stored in a room that was above the recommended storage temperature. Medicines stored, including antibiotics, recommended an upper limit temperature of 25°C; the room had a thermometer in that read 27°C. One nurse told us that they had reported the high room temperature to estates a year ago, but it had not been addressed; they had not completed an incident report. The high temperature was not identified on the patient-led assessments of the care environment (PLACE) 2014

audit. We reported this to staff, and the following day we were assured that the medicine had been condemned, an incident reported had been completed, and the room had been reported to estates.

- Between September 2013 and August 2014, there had been 118 medication errors across community services. The out-of-hours community nursing team accounted for the highest number of these (17 incidents). There was a medicines safety committee established to review arrangements for the safe use of medicines in the trust, which had devised actions to improve medicines management, and had a community pharmacist within its membership.
- We saw that medicines management was discussed at district nurse handovers, with consideration given to patients with new medicine prescriptions and to the time that medications were due to be administered.

Safeguarding

- Staff we spoke with were confident in reporting safeguarding concerns, and were aware of how to escalate concerns to the safeguarding team. We saw safeguarding policies displayed on staff notice boards.
- All community staff were compliant with Safeguarding Level 1, and 96% were compliant with Safeguarding Level 2 training.

Records systems and management

- Patient records were paper-based and kept in patients' homes. We reviewed eight sets of records and found them to contain the necessary information to allow staff to carry out clinical treatment, such as care plans and risk assessments. Each visit was recorded, and contained sufficient information to ensure continuity of care.
- Community staff were required to complete an electronic patient record, using SystmOne; this is an electronic patient record system which records details for each patient. This meant that there was a duplication of records for patients who were receiving treatment at home. Some local GPs and care homes also used SystmOne, and so staff could access notes across those healthcare settings, to acquire current care and treatment plans. The disparity of some services not using SystmOne had been highlighted on the risk register and the trust planned to find a resolution to this by working with local organisations.

Lone and remote working

- There was a lone worker policy in place, and lone working had been identified on the risk register as a potential hazard, as staff were working in isolation.
- Staff we spoke with demonstrated robust lone working practice; for example, district nurses working between 5pm and 8pm attended visits in pairs.

Assessing and responding to patient risk

- We saw that clinical risk assessments were completed and followed for each patient. These included assessments for pressure ulcers, nutrition and mobility.
- All staff we spoke with knew how to escalate risks to patients. For example, district nurses told us that if a patient was at risk of falls, they would refer them to iCARES for a therapy assessment, and they would order appropriate equipment to prevent falls.

Staffing levels and caseload

- The community district nursing team had a 22.25 whole time equivalent (WTE) (15.2%) vacancy rate when we visited. There was a plan for 4.5 WTE band 5 nurses to start in November, and a review of the staff and skill mix was being undertaken as part of the new integrated community strategy.
- District nurses told us that it was difficult to hire agency staff, as staff needed to be competent to work independently, and often agency staff were newly qualified nurses that would not have the appropriate competency levels. Therefore, established staff would often work overtime to bridge staffing gaps; staff told us this was an additional pressure.
- The district nursing team had recently extended their working day from 5pm until 8pm. However, there had been no financial investment to do this, and therefore the team was stretched across the additional hours, which put further pressure on staff to cover both vacancies and the extended working hours. Managers told us that they were trying to manage the additional pressure and were feeding this back to their seniors.
- When we visited, iCARES had 11.35 WTE (14.2%) staff vacancy rate. This was because 10.6% of posts were vacant, and staff were on maternity leave for 3.6% of posts. The manager told us that this had increased referral to treat times.

Deprivation of Liberty Safeguards

- Staff we spoke with knew how to raise concerns regarding Deprivation of Liberty Safeguards (DoLS) or patients' mental capacity. Staff told us how they adapted the delivery of care and treatment for patients with a DoLS in place, or who had mental capacity limitations.

Managing anticipated risks

- We saw that 90% of community and therapy staff were compliant with mandatory basic life support training. However, of this, only 81% of nursing and midwifery staff were compliant. This placed patients at risk, because 19% of nursing and midwifery staff were not suitably trained to provide care if they needed life support.

- Health care assistants we spoke with told us that they had been trained in how to measure oxygen saturation levels in the blood, and knew when and how to escalate patients with falling levels.

Major incident awareness and training

- Staff were aware of the trust major incident policy, and senior staff were aware of their responsibilities in the event of a major incident being declared.
- District nurses could identify, via SystmOne, priority patients who required essential daily treatment, should adverse weather or a local catastrophe occur. However, the community and therapies risk register did not highlight the risk, or the management of patients, should information technology fail. We raised this with a manager, who told us that this had not been identified as a risk.

Are Community health services for adults 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.

Care and treatment was evidence-based, and staff followed current best practice recommendations. iCARES was cited as an example of good practice for crisis support, at home and in nursing homes, in the Kings Fund 2014 Developing Integrated Care report.

Staff were competent to carry out their role, and could access training for further development.

There were positive examples of multidisciplinary working across internal services, and between local healthcare organisations.

Evidence based care and treatment

- Care and treatment was evidence-based, and staff followed current best practice recommendations. For example, the heart failure team had developed local evidence-based protocols for staff to follow based on National Institute for Health and Care Excellence (NICE) guidance.
- They also followed iCARES mirrored guidance for intermediate care services, set out by the Department of Health (DH) entitled 'Intermediate Care - Halfway Home' (DH 2009), which recommended a core multidisciplinary intermediate care team, led by a senior clinician and closely linked to re-enablement services in social care, which targeted patients who would otherwise face inappropriate admissions. iCARES was cited as an example of good practice for crisis support, at home and in nursing homes, in the Kings Fund 2014 Developing Integrated Care report. During the inspection the trust announced they had won a second award from the HSJ (Health Service Journal for innovations in recruitment 2014).
- The trust planned to take part in the National COPD (chronic obstructive pulmonary disease) Audit, starting in November 2014.

Pain relief

- We saw that district nurses asked patients if they were in pain, and advised patients to follow their pain management care plan.
- Some community orthopaedic staff were able to administer trigger point injections (TPI - an injection

that can be used to treat a number of conditions, including tension headache and myofascial pain syndrome) to help relieve pain, in the clinic setting, rather than requiring an additional patient referral to a doctor.

- Staff working in iCARES knew how to refer patients to the pain management team if they were unable to resolve the pain themselves.

Nutrition and hydration

- We saw staff who were completing home visits ask patients about their eating and drinking, and encourage good nutrition.

Patient outcomes performance

- iCARES measured patient outcome achievements for 2013/14. The data showed that 77% of patients achieved their jointly set goals, and 13% mostly achieved their goals. Of the 10% of patients who failed to achieve their goals, 39% were due to a change in their condition, and 26% were due to patients deteriorating. One patient told us "every goal I wanted to achieve I achieved".
- Between January to August 2014, the district nurses screened 74% of applicable patients for dementia. This meant that the majority of patients had an appropriate assessment.

Competent staff

- All community staff had received appraisals for 2013/14.
- All staff told us that they were able to go on study leave and access training to improve their clinical knowledge and skills, except those in MSK (musculoskeletal) services, who told us that they had limited finances to fund study leave.
- Some nurses reported that they had completed the nurse prescriber course; for example, the community alcohol long-term conditions matron was able to prescribe medication.
- Staff working within iCARES told us that there was ongoing shared competencies and clinical supervision between multidisciplinary teams. There were



Are Community health services for adults effective?

competencies for rehabilitation support workers in iCARES, including proficiencies regarding patient consent, multidisciplinary team working, and professional boundaries. This meant that support workers could be suitably trained to complete tasks.

- Nurses felt that they could support students with competencies, and identify learning needs. Student nurses told us that they felt extremely supported by their mentors. Both parties felt that there was two-way learning.
- We witnessed peer review and indirect clinical supervision during the district nurse handovers.

Multi-disciplinary working and co-ordination of care pathways

- Nursing staff told us that they were able to conduct joint visits with specialist teams for additional knowledge and experience; for example, the diabetes clinical nurse specialist attended visits with the district nurses, for patients with erratic blood glucose levels.
- District nurses told us that they had good links with the Hospice at Home team. However, other specialist teams, such as tissue viability, had moved bases from the community into the hospital, and the district nurses felt community links had subsequently deteriorated.
- In 2013 the trust and CCG agreed a revised working model to integrate district nursing into primary healthcare multi-disciplinary teams. However, district nurses and the corporate directorate manager acknowledged that there were issues with district nurses being asked to undertake work normally

expected to be performed by practice nurses, but that district nurses were unable to refuse certain tasks, such as undertaking dressing changes and vaginal swabs. District nurses told us that this was because practice nurses were not appropriately skilled to do some procedures, and were not always available when patients required treatment. We saw evidence of district nurses attending GP practice meetings, and they told us that they often attended GP team building days to improve working relationships.

- During our inspection, two members of the Short Term Assessment and Re-enablement Service (STAR) were on a six-week trial working alongside the district nursing team, to gain understanding of each other's role, and how they could benefit patient care by working in partnership. STAR is a service jointly funded by Sandwell Metropolitan Borough Council and Sandwell and West Birmingham Clinical Commissioning Group, to work in partnership with iCARES and therapy services, to deliver integrated re-enablement support. This demonstrated shared learning and partnership working.
- The community orthopaedic staff told us that they worked closely with radiology, and attended some radiology team meetings to share clinical learning and joint service planning.
- The community alcohol long-term conditions matron told us that they had close links with local voluntary alcohol services, and attended service user focus groups within these organisations. This meant that they were able to offer support to patients at focus groups, and work with voluntary services to provide joined-up care.

Are Community health services for adults caring?

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

All patients and carers spoke positively about the care provided.

Patients received compassionate care, and we witnessed positive interactions between patients and staff.

Staff discussed planned care and treatment with patients, and provided information to reinforce understanding. The patient experience questionnaire for community-based services showed that 92% of patients reported being involved in decisions about care or treatment. Staff promoted self-care to encourage patients to maintain their independence.

Staff provided emotional support for patients, and their carers and families.

Compassionate care

- All patients and carers we spoke with told us that they were extremely happy with the care they received. One patient receiving district nurse care commented “I have excellent care”, and another “they (the nurses) are very kind and considerate”.
- Staff told us that they tried to see the same patients to establish continuity of care, and we witnessed clear rapport between staff, patients and carers.
- Staff considered all the needs of patients. One patient receiving district nursing care told us “they always ask me if they can do anything else for me”.

Dignity and respect

- Patients were treated with compassion, dignity and respect.
- We saw that patients were asked for consent, and spoken with in a respectful way.
- We observed staff asking to use hand-washing facilities when treating patients in their own homes, and asking for permission before they took a seat.

Patient understanding and involvement

- We saw staff discuss planned care and treatment with patients, and provide information to reinforce understanding. We saw a district nurse treat a patient

who had learning disabilities. We saw that the nurse took great care in assuring that the patient understood the treatment, and why it was required. Patients were always given time to ask questions.

- There was a monthly patient experience questionnaire for community-based services, including district nursing and iCARES. The results from July to September 2014 showed that 92% of patients reported being involved in decisions about care or treatment as much as they wanted to be; 87% of patients reported that they always received enough information to manage their health; 87% also reported that they had enough support from their health care professional to manage their health; and 95% of patients knew what to do if their condition worsened.

Emotional support

- All staff we spoke with told us that part of their job was to provide emotional support, not just to patients, but also their carers and families. During home visits, staff demonstrated knowledge of people and their unique situations, and provided tailored emotional support.
- All patients were given phone numbers of staff, so that they could get support as and when required. All patients that we spoke with told us that they knew how to contact services if needed.
- Nursing staff told us that they assessed nursing candidate's emotional support at interview through role play scenarios, and that this had been effective in identifying successful candidates.
- Staff told us that they provided emotional peer support for one another, and that they could access counselling services provided by the trust if they needed additional support.

Promotion of self-care

- We saw that therapy staff provided equipment to enable people to maintain their independence. We witnessed physiotherapists in the Parkinson's disease clinic discuss with patients ways to encourage and maintain their independence.
- Staff across community services told us that they promoted self-care. However, the staff commented that patients discharged from the acute trust often required

Are Community health services for adults caring?

additional input compared to that delivered prior to admission. They told us that this was because the acute services did not promote self-care, and restricted

patient's independence; consequently community staff needed to retrain patients to self-care with certain procedures, such as the administration of insulin or eye drops.

Are Community health services for adults responsive to people's needs?

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

iCARES was an open access integrated care service that managed adults with long-term conditions to avoid unnecessary hospital admissions, maintain health and well-being, and improve independence. Between January and June 2014, iCARES prevented 270 hospital admissions, and we found multiple examples of how this was achieved. This was an excellent example of a service providing the right care, at the right time, to prevent unnecessary hospital admissions.

Across the service, when possible, people were treated in their own homes or community clinics. Many services had practices in place to prevent unnecessary hospital admissions; a good example of this was the community alcohol service, which often worked in A&E to prevent alcohol-related admissions.

All community staff we spoke with told us that patient referrals from the hospital often lacked detail, and therefore staff would have to respond to the needs of the patient at first contact. Information provided by the trust showed that 43% of all community referrals were seen within the first week; this increased to 78% in the first three weeks.

Service planning and delivery to meet the needs of different people

- iCARES was an integrated care service that managed adults with long-term conditions irrespective of their diagnosis, location, or age. It included a range of health care professionals, who aimed to avoid unnecessary hospital admissions, maintain health and well-being, and improve independence. When possible, people were treated in their own homes or community clinics, rather than in the hospital setting, for interventions such as the administration of intravenous medicines or therapy services. The service was open 8am to 8pm, seven days a week.
- District nurses told us that they met with local care homes to provide clinical education about conditions, to prevent avoidable hospital admissions.
- Dietitians told us that they worked closely with community nutrition nurses and Homeward (a home enteral feeding company) nurses to ensure that patients with feeding tubes received adequate training to self-

manage. They told us that they helped to avoid feeding tube-related hospital admissions; for example, some dietitians were able to change balloon gastrostomy tubes in the community, rather than the patient being sent to hospital for this to be done.

- The community alcohol service was operational Monday to Friday, 9am to 5pm; however, we saw an example of a patient who required alcohol detoxification over the weekend, and therefore, overtime was authorised for staff to be on duty. The team also went into A&E to prevent alcohol-related admissions, especially for patients who were regular attenders.
- The community orthopaedic staff told us that they worked two days a week in A&E, with the rapid response team, to prevent orthopaedic-related admissions.
- The trust told us that there was a safeguarding and dementia lead that provided professional leadership across the trust. Yet, staff including nurses, were not aware of this and told us that there was no longer a dementia lead in post to gain specialist or individualised management advice. Staff were aware of the dementia awareness course that they could attend and the dementia champions (staff who had training in dementia care) in the trust. However, staff felt that they had limited support about how to tailor care and treatment for people living with dementia.
- We were told that staff had access to translation services if required.

Access to the right care at the right time

- Information provided by the trust showed that 43% of all community referrals were seen within the first week; this increased to 78% in the first three weeks. The continence service had 5% of patients waiting longer than 18 weeks. Recent policy change had impacted on the continence service waiting times.
- Between January and June 2014, iCARES prevented 270 hospital admissions via the primary care assessment and treatment (PCAT) centre, and 527 admissions by home visits. An example of this included where the district nurses referred a patient who had been discharged from hospital and who could not mobilise upstairs to use the bathroom; iCARES arranged for a

Are Community health services for adults responsive to people's needs?

commode to be delivered the same day, and the following morning when the nurse visited, iCARES had put in place a key safe and additional healthcare support. The nurse told us that if iCARES had not arranged these interventions the patient would have been readmitted. This was an example of a service responding to provide the right care, at the right time, to ensure patients could be treated in the community to avoid a hospital admission.

- The aim of iCARES was to assess patients requiring rehabilitation within 15 days. The average therapy response was below eight days for occupational therapy, and speech and language therapy, but 15.5 days for physiotherapy.
- The tuberculosis specialist service had started screening patients for latent tuberculosis infection (where people have been infected with the tuberculosis bacteria, but do not have any symptoms of active disease) and blood-borne viruses (a virus spread through contamination by blood and other body fluids, such as Hepatitis B and Hepatitis C) at GP surgeries. Between April and October 2014, 277 patients had been screened. This promoted early identification and treatment.
- Data for the number of patients who did not attend (DNA) their booked appointments for allied health professional (AHP) clinics showed that rates averaged at 6.7%, between April to July 2014. This was better than the trust target of 8.5%. However, the DNA rate for musculoskeletal (MSK) services were consistently above the target, averaging at 13%. Staff told us that services had implemented strategies to reduce the number of patients that DNA clinic appointments, such as the use of appointment cards with all the services contact details on, as well as text message and phone call reminders.
- Patients receiving treatment from the heart failure team were able to choose their preferred clinic location from nine options, and clinics would phone patients to ask for their preferred appointment time. This helped to maximise patient attendance.

Discharge, referral and transition arrangements

- There was open access to iCARES; patients could self-refer, or be referred via other healthcare professionals. iCARES telephoned each patient referred, to assess the urgency of the care and treatment required.

- iCARES facilitated patients to integrate into community groups, to promote self-care, group support, and safe discharge from the service. For example, patients requiring support with their communication would be seen by a therapist and then, if appropriate, supported to attend a group session organised by Speakability (a national charity that supports and empowers people with Aphasia). iCARES had close relationships with such charities, and supported training provided to staff and volunteers.
- Between January and June 2014, PCAT discharge data showed that 67% of patients returned home, 23% were referred for an intermediate care bed, and 10% were admitted to hospital. Patients with motor neurone disease (MND) were not discharged from the service due to their complex needs.
- All community staff we spoke with told us that patient referrals from the hospital often lacked detail, and therefore staff would have to respond to the needs of the patient at first contact. For example the district nurses told us of two recent referrals relating to poor discharges. One patient had received end of life care in hospital. This had not been communicated to the community team; consequently, the district nurse had to arrange appropriate care at the first home visit. Another patient was discharged with a cannula (a tube inserted into the body, often for the delivery or removal of fluid) in place, but this was not communicated. This meant that staff were constantly reacting to the poor quality referrals from the hospital, which meant that visits took longer than expected. They had started to complete incident reports, and a manager had put their concerns in writing to the chief executive officer (CEO), and met with ward managers to try and resolve this issue.
- There was a co-ordinator who prioritised district nurse referrals and delegated them to staff with the appropriate skill mix. Urgent referrals were sent via a central contact centre, and were alerted to the whole team via text message. Once a team member had picked up the referral, the whole team would receive another message to confirm that the referred had been allocated. This meant that the whole team was kept up to date with referrals and patients who required urgent assessments.
- Staff reported difficulties obtaining funding for equipment for patients who were referred with a GP out

Are Community health services for adults responsive to people's needs?

of the community catchment, or who had a GP in the local area, but the patient lived outside the community catchment. They told us that this meant that discharges from services were often delayed.

Complaints handling (for this service) and learning from feedback

- All staff we spoke with were aware of the complaints procedure, and told us that they tried to resolve complaints locally as they arose.
- District nursing notes held in the patient's homes had information about how to complain. However, not all patients knew that this information was there. We spoke with 12 patients receiving home care from district nurses or iCARES, all of whom told us that they felt able to raise concerns with staff, although four patients did not know how to raise a formal complaint to senior management.
- We saw complaints information that documented the outcome from each complaint. For example, one person had complained that the district nurses did not arrive to change a dressing. The district nurse team believed that the patient's partner was willing to undertake dressing changes. The nursing team were informed that they must be clear in their communications with patients, and summarise the conversation.
- We saw evidence that both complaints and compliments were shared at iCARES team meetings.

Are Community health service for adults 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.

Leadership within local services was strong, and managers demonstrated a clear understanding of their services, and were aware of future challenges.

Staff told us that they were happy to come to work, and spoke positively of the contribution they made to patient care.

Services engaged with patients to gain feedback and improve services. Staff were not familiar with the trust board. They felt hospital services and senior managers did not understand the role of community services. There was some engagement with staff, although many staff felt that community services were the 'poor relation', compared to acute services, and that the two had not been integrated. Staff were anxious about the future of services, subsequent to the major workforce changes, and felt disengaged with the planning.

There were notable examples of innovation, including the iCARES team, who had won a Nursing Times Award for integrated care in October 2014; the community alcohol service had integrated into the trust; and the Cape Hill district nursing team participated in an Aspiring to Clinical Excellence project.

Vision and strategy for this service

- Specialist nurses told us that there was a lack of contingency planning for the future of services; for example, some staff were approaching retirement age, and others were due to go on maternity leave, but replacement staff had not been sourced. They had concerns that if new staff were appointed after substantive staff had left, new staff would not be competent, as there would be no handover, or on-site clinical training. This was of particular concern for the tuberculosis and respiratory specialist teams.
- Following the inspection the trust made us aware that specialist nursing review 2014/15' had been carried out.
- Most staff that we spoke with were anxious about the major workforce restructuring planned between 2014 and 2016. They told us that they felt disengaged, and that already, posts were being delayed in recruitment, or not recruited at all; for example, the head of nutrition

and dietetics post had not been recruited to since the post holder had left, and iCARES also had a post for which recruitment was being delayed, due to the changes.

- The iCARES manager told us about the plans and vision for the future of the service; for example, expanding the service and achieving better patient outcomes.
- We were told by the corporate directorate manager that plans were being investigated to develop a pathway, whereby GP non-emergency hospital referrals went via the PCAT (primary care assessment and treatment) centre, to assess if PCAT could intervene and treat patients locally, to prevent hospital admissions. The service, along with the clinical commissioning group (CCG), was looking at how this could be funded and implemented.
- A system was planned for the district nursing team, called the 'red stream'. The intention was to have a team of staff completing scheduled visits, so that patients knew visit times; and another team would complete unscheduled 'red stream' responsive visits, such as urgent patient referrals. However, not all staff we spoke to knew about this plan and some felt disengaged with the service planning.

Governance, risk management and quality measurement

- We saw minutes that showed that local managers attended bi-monthly community and therapies management meetings, which discussed and monitored the workforce, quality and governance, and clinical effectiveness, across the division.
- Band 7 and 8 staff told us that they were given the opportunity to raise concerns about quality and safety at the monthly 'Hot Topics' meeting chaired by the CEO. We saw that staff were encouraged to complete discussion topic reply sheets, to highlight relevant issues.
- District nursing staff told us that it took too long for new staff to gain access to and receive training for SystemOne. This meant that new staff could not input patient information onto the system until they had received training, and therefore, they relied upon other staff to

Are Community health service for adults well-led?

complete electronic entries for patients that new staff had treated. Staff told us that this had a negative impact on care quality, and increased pressure on staff. The trust told us that training happened every two to three weeks, and that there was no waiting list.

Leadership of this service

- Staff told us that although the CEO was visible, they did not know most of the trust board, and some nurses did not know who the chief nurse was.
- Staff told us that there was no 'back to the floor' style scheme to enable senior trust members to visit or work within community departments. Staff, including local managers, told us that they felt hospital services, corporate directorate, and clinical group managers did not understand the role of community services. The corporate directorate manager told us that the CEO ran community drop-in sessions, but none of the staff we asked about these were aware of them.
- Staff told us that communication from the trust to community services was inadequate. Band 3 to band 6 staff told us that they felt community services were the 'poor relation', compared to acute services, and that acute and community care had not been integrated. Band 7 and 8 staff felt that community services were starting to be integrated into the wider trust, especially as a result of the community CQUINs (commissioning for quality and innovation). The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
- Staff told us that most trust initiatives and study days were focused around the acute trust, such as the 'Ten out of Ten' patient safety standards checklist, which was ten basic checks to be carried out for each patient admission, with the aim to preventing harm. They also felt that mandatory training was hospital-focused, and did not consider the community setting enough.
- Community band 7 and 8 nurses told us that they had attended the trust leadership course to develop their leadership skills.
- All services we visited told us that recruitment took a long time to complete, in some cases, up to six months after the candidate had been offered a post. Staff felt that this put pressure on substantive staff to cover vacant posts, and this increased waiting times, as was the case in iCARES.

Culture within this service

- All staff we spoke with told us that most community services were friendly, and that they were happy to come to work.
- All staff we spoke with were positive of the contribution they made to patient care, and the majority were positive regarding the teams they worked in. In the 2013 National NHS Staff Survey, staff job satisfaction was better than the national average.
- Specialist nurses, including respiratory and tuberculosis services, told us that they felt that they were not recognised as a service. They told us that in the past, during winter pressure, the trust had made them work on the wards, and that this took them away from patients that needed specialist advice and treatment. Nurses told us that recognition regarding winter pressures was focused on the hospital, and that the trust did not recognise the winter pressures in the community. However at the time of the inspection this was not planned.
- Staff sickness rates for nursing and midwifery were 6.3%, and for administrative and clerical staff were 5.5%. Managers had received training to help manage sickness rates.

Public and staff engagement

- There was a patient experience questionnaire for community-based services, including district nursing and iCARES. We saw minutes to show that results were discussed in team meetings about how to improve the service.
- There were bi-monthly patient focus groups for patients receiving treatment from iCARES, to feedback any comments they had, and engage them with service delivery.
- At the August 2014 trust board meeting, the board heard the story of a patient who had been cared for through iCARES. The patient expressed her contentment with the service. The patient also fed back learning points for the service. This meant that the board were able to obtain direct feedback, and engage with patients using community services.
- The trust invited members of the public to nominate a staff member or team that provided outstanding customer care, for an Excellent in Care Award. We met two staff members who had been nominated for the 2014 awards; they told us that the awards motivated

Are Community health service for adults well-led?

staff, and that they felt privileged to be nominated. We met one carer who had nominated a staff member. They told us that “X gives invaluable care and we want this recognised”.

- The iCARES manager had developed a quarterly newsletter for the directorate, to update staff on the latest directorate news. There was a ‘Your Voice’ section that collated and proposed actions to address feedback from a staff online questionnaire. For example, 40% of staff had reported that they did not feel engaged with the service; the actions were to have regular updates from leaders, hold team meetings, and establish dates for engagement events. AHPs told us that they appreciated this, and recognised that the service tried to keep staff informed.

Innovation, improvement and sustainability

- The community alcohol long-term conditions matron told us that they had won the trusts ‘New Leader’ employee of the year 2013, and regularly spoke on local radio programmes to highlight alcohol-related issues, and associated risks to the community. They told us that they were proud that the trust recognised alcoholism as a long-term condition. However, they stated that their post was at risk of being taken over by an alcohol-related issues charity, and therefore they would not be a trust staff member, or have access to trust facilities, such as IT, which was crucial to their work.

- The iCARES team won a Nursing Times Award for integrated care in October 2014.
- The iCARES manager, who had been highly commended regarding outstanding leadership at the trusts 2013 staff wards, had spoken about the service at a Kings Fund conference, and a national rehabilitation event.
- The community division contributed to the National Audit of Intermediate Care 2013, and planned to continue this in 2014/15. The audit provides an overview of intermediate care and provision in England.
- The district nursing team at Cape Hill were taking part in an Aspiring to Clinical Excellence project, to implement strategies designed to improve early diagnosis and management, with the aim of avoiding unnecessary hospital admissions.
- Local audits and clinical pilots were being followed in community services. For example, the MSK physiotherapy service conducted an audit to investigate the pain scores of patients with Greater Trochanteric Pain Syndrome; this is a condition that causes pain over the outside of the upper thigh, and requires an injection by the community orthopaedic service. From this, they could analyse how effective injections were to control pain, and adapt their practice accordingly.