Norfolk Community Health and Care NHS Trust

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Community health services for adults

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Norfolk Community Health and Care 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 Norfolk Community Health and Care NHS Trust and these are brought together to inform our overall judgement of Norfolk Community Health and Care NHS Trust

Summary of findings

Ratings

Overall rating for Community health services for adults	Good
Are Community health services for adults safe?	Good
Are Community health services for adults effective?	Good
Are Community health services for adults caring?	Good
Are Community health services for adults responsive?	Requires Improvement
Are Community health services for adults well-led?	Good

Summary of findings

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Summary of findings

Overall summary

We saw evidence of staff being encouraged to report incidents and had access to the incident reporting system. Staff could explain the types of incidents they would report. We saw evidence that incidents had been investigated and changes to practice had been made as a result. We also saw evidence the Trust reviewed trends in incidents. For example, because of the numbers of incidents being reported that related to mobile working, community teams were shadowed and interviewed so the Trust could have a better understanding of the problems teams were facing and thus find appropriate solutions.

There was a safeguarding vulnerable adults policy and procedure in place. We saw this policy was easily available for staff. Staff were able to describe what constituted abuse, the types of abuse and the procedures to follow if abuse was alleged or suspected. We found staff had varying levels of understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLs).

There were systems and protocols in place for sharing information with other healthcare professionals, such as with General Practitioners and medical staff from other NHS Trusts. Paper records were stored securely in clinics and health centres.

Staff were aware of the Trust's lone working policy and knew what they should do to keep themselves safe when working alone in the community. Lone working arrangements were in place in each area. We saw evidence that patients had individual risk assessments in place, such as for the risk of falls, the risk of developing pressure ulcers and regarding pain relief.

Some managers and staff within the adult community service did express concern regarding staffing levels and these had been ongoing for some time. We saw that the Trust were actively trying to recruit staff and the impact of this had started to be felt in some areas. The Trust had developed a staffing model which ran alongside the work on transformation of the integrated community service. This was designed to improve the quality and efficiency of community services. Although it was recognised by everyone in the Trust that there had been some initial difficulties with the system, staff were overwhelmingly positive about it and thought it would continue to develop further.

The Trust's policies and clinical guidelines were based on the National Institute for Health and Care Excellence (NICE) guidelines.

Adult community services monitored the quality of the service they were providing through a range of different audits. Performance of services was monitored through a locality management structure which reported to various sub committees of the board and subsequently into the Trust board.

We saw examples of positive outcomes for people who used the service. The community intravenous (IV) therapy team had evidence of clear treatment pathways. Outcomes of IV treatment were constantly monitored by the microbiology service at the local acute NHS Trust.

Staff were appropriately qualified, skilled, experienced and competent to carry out their roles safely and effectively and in line with best practice. All the patients we spoke with in clinics and in patients' homes were complimentary about the ability of the community staff. There was effective multi-disciplinary team (MDT) working within the adult community service as well as with other health and social care providers.

People who used the service were treated with kindness and compassion. Almost all the people we spoke with were complimentary about the staff and the care and treatment they received. We contacted patients who used the community service by telephone. The vast majority of comments were positive about the care the patient received. We saw staff involved the patients they were caring for in their care planning.

People received personalised care in the community. Staff delivered care and treatment that focused on people's needs, preferences and wishes. People's health and independence had been promoted. The Trust had access to an interpreting service. Staff knew how to access interpreting services

We observed the community nursing and therapist teams working together to ensure all patients on the daily list

Summary of findings

were visited as planned. The community staff confirmed patients were told the day of the visit but were not given a time. Some patients and staff told us they would like to see more continuity of nursing care Some patients commented that they would prefer to be told if their home visit would be AM or PM. Staff told us it was more difficult for patients to access the stroke pathway if they didn't start in it and we saw how this had proved difficult for one patients who had suffered a stroke.

The Trust monitored the responsiveness of the adult community service and monthly reports were provided to the Trust board. The access scores were higher than the Trusts targets. This meant the vast majority of patients were getting a responsive service. However there were some concerns regarding waiting times for appointments for some outpatients' and specialist clinics due to inadequate staffing numbers, unfilled vacancies and increased demands and workloads. The Trust achieved the 18 week referral to treatment target (RTT) with performance of 98% in July 2014. The Trust monitored its performance and presented a monthly Integrated Performance report to the Trust board. In July, all services achieved 100% of RTT times with the exception of MSK physiotherapy, podiatry surgery and specialist nurses epilepsy management.

There was dedicated support within localities for clinical governance. Local risk registers were maintained and risks were placed on the Trust-wide risk register. Some risks were not reviewed in a timely manner and had been on the register for some time.

The Trust had been through a transformation programme for community services and staff told us they had been involved in the consultation. Staff told us that initially there was anxiety amongst staff about the transformation programme and it had affected morale. Many staff told us the that although there had been difficulties, the Trust had listened and responded to these and they thought communication between staff and senior managers and Trust executives had improved. There were some staff who did not think their views had been listened to.

There were clear line management arrangements in place. Staff we spoke with were committed to providing good quality care and were proud of their work.

Summary of findings

Background to the service

Norfolk Community Health and Care NHS Trust operates in and around Norfolk, offering a wide range of NHS healthcare services including a range of community health services for adults.

Community health services for adults are provided in four localities comprising North, South, West and Norwich. The Trust manages nine community hospitals and 20 community virtual beds, numerous clinics and health centres, and also works from GP surgeries. Services provided include community nursing; therapies and rehabilitation and specialist nursing services; outpatient and health centre clinics for people with a variety of health conditions, including neurological conditions, Lymphoedema, dermatology, stroke, diabetes, epilepsy, musculoskeletal disorders, podiatry and tuberculosis. The community nursing service included home visits to people with long term conditions, terminal illness, people prone to falls, and the frail and elderly.

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams Executive Nurse/director of Governance, Bridgewater Community Healthcare NHS Trust.

Team Leader: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: health visitor, school nurse, GP, medical consultant, nurses, specialist palliative care nurse, university lecturer, therapists, social worker, dentist, senior managers and experts by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Norfolk Community Health and Care NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

The inspection team always looks at the following core services at each inspection

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Summary of findings

In addition, the inspection team also looked at community dental services.

Before visiting, we reviewed a range of information we held about Norfolk Community health and Care NHS Trust and asked other organisations to share what they knew. We carried out an announced visit on 16, 17 and 18 September. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 2 October 2014 to three of the inpatient hospitals.

What people who use the provider say

The majority of people we spoke with were positive about the care and treatment they received. People said they felt safe using the service and they were treated with respect, kindness and compassion by staff.

There is no current requirement for community Trusts to adopt the Family and Friends Test (FFT), but Norfolk implemented the FFT in community services in July 2013. The FTT is a national initiative and aims to ensure patient experience remains at the heart of the NHS, so members of the public can see what patients think of local services, and that service quality is transparent to all. A simple score is generated by taking the proportion of respondents who would be 'extremely likely' to recommend the service, minus the proportion of those who say they are 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely' to recommend it. Patients are then encouraged to comment on why they gave that score, enabling services to understand what really matters to them.

The national target was for a 75% positive response and 15% sample size. The Trust had not yet supplied sample size. Between July 2013 and March 2014 the Trust reported an overall score of 79% positive responses, the lowest result being 72% in July 2013 and the highest being 86% in March 2014.

There had been 140 comments on the Trust on the patient opinion website, with 128 of these being positive in nature. Of the negative reports, six were regarding staffing levels and waiting times, three were around staff attitude and three regarding poor care.

Good practice

- There was good multi-disciplinary working within the teams we inspected.
- Staff were very caring and were committed to provide high quality care to patients.
- The Trust was an integrated provider of health and social care working with Norfolk County Council.

Following a Section 75 of the NHS Act 2006, the Trust had agreed a joint management structure for health and social care. Health and social care professionals will be co-located in teams and will share access to health and social care records as well as sharing referral processes and case management.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Continue to work with commissioners of the service to ensure services are responsive to patient need. This should include, physiotherapy, podiatry, speech and language therapy, epilepsy and Lymphoedema services.
- Review the pathway for patients who have suffered a stroke outside of the Trust boundary to ensure all

patients have the same access to services. The pathway is provided by another NHS Trust and we will raise this with the commissioners at the quality summit.

- Develop a process to monitor access to services that are not part of RTT reporting targets such as family planning services.
- Continue the action already in place to improve the staffing levels in the service.
- Carry out an audit to review the Trust performance in relation to the continuity of nursing staff within the community nursing service.

Norfolk Community Health and Care NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Good

Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

Summary

We saw evidence of staff being encouraged to report incidents and had access to the incident reporting system. Staff could explain the types of incidents they would report. We saw evidence that incidents had been investigated and changes to practice had been made as a result. We also saw evidence the Trust reviewed trends in incidents. For example, because of the numbers of incidents being reported that related to mobile working, community teams were shadowed and interviewed so the Trust could have a better understanding of the problems teams were facing and thus find appropriate solutions.

The community clinics and outpatients' departments we visited were generally clean and reasonably tidy. Reusable sterilised instruments used, for example, in podiatry clinics were traceable. This meant the equipment could be identified if there were any subsequent problems with infection control. Appropriate dressing techniques were followed and good infection control practices were adhered to.

There was a safeguarding vulnerable adults policy and procedure in place. We saw this policy was easily available for staff. Staff were able to describe what constituted abuse, the types of abuse and the procedures to follow if abuse was alleged or suspected. We found staff had varying levels of understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLs).

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Are Community health services for adults safe?

Some managers and staff within the adult community service did express concern regarding staffing levels and these had been on-going for some time. We saw that the Trust were actively trying to recruit staff and the impact of this had started to be felt in some areas. The Trust had developed a staffing model which ran alongside the work on transformation of the integrated community service. This was designed to improve the quality and efficiency of community services. Although it was recognised by everyone in the Trust that there had been some initial difficulties with the system, staff were overwhelmingly positive about it and thought it would continue to develop further.

Incidents, reporting and learning

In September 2014 the integrated community teams reported a total of 438 incidents. The top three reporting categories were:

- Pressure ulcers (52%)
- IT issues (10%)
- Staffing levels/Skill mix (6%)

There were 134 serious incidents requiring investigation (SIRI's) within the integrated community teams between June 2013 and May 2014. Of these 132 were attributed to grade 3 or grade 4 pressure sores. During 2013/14 the Trust implemented a pressure ulcer validation group to review the entire reported grade three and four pressure ulcers. Root cause analysis investigations were undertaken on all pressure ulcers that were grade 3 or higher which enabled them to identify if they were avoidable or not. Available pressure ulcers are those that occur whilst the patient is under the care of the Trust. From July 2013 to May 2013 there had been 61 avoidable pressure ulcers ranging from grades 2-4 in the integrated community teams. The data does not break down the number of ulcers by grade within the integrated community teams, but overall, the number of avoidable grade four pressure ulcers between July 2013 to May 2014 throughout the Trust was 15.

All the staff we spoke with said they were encouraged to report incidents, using an online reporting system (Datix). Staff could explain how to report incidents and described a range of what they would report, such as medication errors, pressure ulcers grade 3 and 4 and unsafe staffing levels. We saw all staff working in adult community services had access to the electronic reporting system. Two members of staff confirmed they had used Datix when they felt the staffing level was unsafe. Staff told us they felt supported by their line managers. They told us their senior managers acted upon concerns when they were escalated.

We saw evidence that incidents had been investigated and changes to practice had been made as a result. For example, two members of staff and their line managers confirmed as a result of concerns raised about staffing levels, the Assistant Director visited the relevant locality, spent a day out with a community team member and actioned the recruitment of more staff to increase staffing levels.

There was openness and transparency when things went wrong. Themes from incidents were discussed at locality Quality and Governance meetings which were held monthly. The information was cascaded down to frontline staff. For example, the minutes of the meeting on 31 July 2014 evidenced a manager being designated to look at pressure ulcer incidents and gave the results of root cause analysis by the pressure ulcer validation team. This also demonstrated the Trust were learning from incidents.

Cleanliness, infection control and hygiene

The community clinics and outpatients' departments we visited were generally clean and reasonably tidy. Separate hand washing basins, hand wash and hand gel were available in all the clinics. We observed staff washing their hands and using antibacterial hand rub in-between contact with patients and on entering or leaving the area. Staff working in the clinics and in patients' homes demonstrated appropriate hand washing techniques to reduce the risk of spreading infection. The Trust had an up to date hand hygiene policy in place.

We saw staff wore clean uniforms with arms bare below the elbow, as required by the Trust's policy. Personal protective equipment (PPE) was available for use by staff in clinical areas and in patients' homes. We observed staff wearing PPE such as disposable aprons and gloves when required and using correct techniques for dressing wounds. Used instruments were disposed of correctly.

Community nursing staff told us they had adequate supplies of sterile wound care packs in order to carry out dressings on patients wounds in their homes. Community nurses were provided with hand hygiene gel to take around with them.

Good

Are Community health services for adults safe?

Staff in general were aware of Trust policies and procedures and knew where to look for them on the intranet, including an awareness of the procedures to follow in the event of needle stick incidents. However, we found staff working in the blood clinic were not able to give an account of the steps to take in the event of a needle stick incident. The staff had no knowledge of post-exposure prophylaxis and were unable to show us the policy. This exposed staff and other patients to harm in the event of an incident and might create an infection control problem.

Reusable sterilised instruments used, for example, in podiatry clinics were traceable. This meant the equipment could be identified if there were any subsequent problems with infection control.

The Trusts rate for new urinary tract infections among patients with a catheter has been above the England average since October 2013. Staff told us there was no ongoing competency checks of how to catheterise a patient but there were clinical guidelines in place. The Trust monitored all incidents of catheter acquired urinary tract infections and has an action plan to reduce these.

We observed nursing staff carry out wound dressings in patients' homes. Appropriate dressing techniques were followed and good infection control practices adhered to.

Maintenance of environment and equipment

Patients were seen in a variety of settings within the adult community service. Some outpatients' clinics were in older buildings and so the layout and facilities were not as suitable as the more modern community health centres. On the whole, the environment was clean and reasonably tidy and uncluttered. We noted, however, in the Norwich and Community Hospital outpatients' clinic, one staff office was cluttered with large equipment and staff had to climb over the equipment to get access to the computer terminals. This was a hazard to staff safety.

Staff working in clinics knew how to report faults or request maintenance. We saw risk assessments had been undertaken in the clinic settings and steps had been taken to control the risk. This meant staff were taking steps to make the environment as safe as possible for both staff and patients.

We also saw risk assessments in place for community nursing staff, for example risks to staff of dogs being in the patients home and inadequate lighting outside the property. This meant the risks to staff were being highlighted and mitigated where possible.

Medicines management

Staff who were trained to prescribe, such as the community matrons, were able to prescribe medicines for patients in their care.

Staff knew how to report medication errors through the Datix incident reporting system. We were told there had been no medication errors reported in recent months.

Safeguarding

There was a safeguarding vulnerable adults policy and procedure in place. We saw this policy was easily available for staff. Staff were able to describe what constituted abuse, the types of abuse and the procedures to follow if abuse was alleged or suspected. We saw safeguarding procedures and incidents had been discussed at team meetings. Staff told us they felt confident reporting concerns about safeguarding and we saw evidence of this and how local procedures were followed.

Staff also demonstrated their understanding about safeguarding children and we saw the children's safeguarding policies were also available.

Safeguarding adults and children's training was mandatory for all Trust staff. Clinical staff were also required to complete level two safeguarding training. According to the Trust's annual quality report for 2013/2014, more staff received training in safeguarding adults and children. In March 2014, 80.82% of staff had been trained in safeguarding adults and 86.6% of staff had been trained in safeguarding children. The clinical staff we spoke with all said they had received safeguarding training.

Records systems and management

There was a safeguarding vulnerable adults policy and procedure in place. We saw this policy was easily available for staff. Staff were able to describe what constituted abuse, the types of abuse and the procedures to follow if abuse was alleged or suspected. We saw safeguarding procedures and incidents had been discussed at team meetings. Staff told us they felt confident reporting concerns about safeguarding and we saw evidence of this and how local procedures were followed.

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Are Community health services for adults safe?

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Staff could describe how people's confidentiality was protected. There had been no incidents of breach of confidentiality in regard to patients' records since 2011.

The Trust's compliance with the Department of Health Information Governance toolkit was assessed as 76%, which was rated as satisfactory. Information governance was included in the two day mandatory training programme for staff. The training highlighted awareness of how to prevent breaches of confidentiality and unwanted disclosure of confidential information.

In some of the localities the Trust had implemented an electronic system for the management of the community visits. Staff had been provided with computers.

Lone and remote working

Staff were aware of the Trust's lone working policy and knew what they should do to keep themselves safe when working alone in the community. Lone working arrangements were in place in each area.

One team of community staff told us they phoned each other if they were late getting back to the office and two therapists who worked closely together were in constant contact with each other daily to update themselves in regard to home visits. We were told staff also used text messaging to report their whereabouts and to confirm they had returned home safely. Staff said this worked well for them and they felt safe using this system. However, not every member of staff felt the lone working arrangements were enough to make them feel safe, especially when working on dark evenings in areas where they felt vulnerable.

Assessing and responding to patient risk

We saw evidence that patients had individual risk assessments in place, such as for the risk of falls, the risk of developing pressure ulcers and regarding pain relief. During a home visit, a community nurse was observed reviewing a patient's care plan and their risk assessments. We saw these were updated accordingly. On another home visit we accompanied an occupational therapist who was visiting a new patient. This patient had been discharged home following a fall. The occupational therapist carried out a detailed risk assessment and provided the patients with solutions to help reduce their risk of further falls.

We saw a patient who had been discharged into the care of the community team. The patient expressed how pleased they were to have had a full assessment by an occupational therapist. The patient felt the fear of falling again had been overcome once the therapist explained about falls prevention and the use of a walking aid. The patient told us the therapist had helped them regain their independence and self-confidence.

Staff were able to access equipment for patients if their risk assessment indicated it was required. For example, we saw a patient whose waterlow score indicated a pressure relieving mattress was required. The nurse was able to order this equipment and they told us it would be delivered the following day.

One locality manager told us they kept a community satellite store for walking aids and other equipment in readiness for patients who might need them promptly. For example, in the case of a person prone to falls a walking aid could be supplied for immediate use. This would enable the therapist to advise the patient how to use the equipment correctly but avoid further delay.

Staffing levels and caseload

Some managers and staff within the adult community service did express concern regarding staffing levels and these had been on-going for some time. We saw that the Trust were actively recruiting staff and the impact of this had started to be felt in some areas. The vast majority of staff as well as senior managers in all of the localities confirmed the staffing levels had improved recently and staff felt confident these improvements would continue to improve as more staff were recruited. We saw there was a range of activities in place such as recruitment events, reducing the time it took to recruit new staff and over recruiting to posts in order to match and not be behind

Good

Are Community health services for adults safe?

staff turnover. The Trust were also considering a recruitment campaign outside of the United Kingdom to help them address their recruitment challenges. Bank staff were utilised as necessary and we saw evidence that bank staff received induction and access to mandatory training.

The Trust monitored vacancies in their localities. The North and West localities had the highest number of clinical - registered WTE vacancies at 11.49 and 17.19 respectively. The South had the lowest, with 2.52 WTE clinical - registered vacancies. We noted in the West locality, there was just 1.29 WTE clinical – unregistered vacancy and 1 WTE past had accepted but had not yet started.

In community nursing, the total vacancies were 18.95 WTE, however, all but 2 WTE posts had been recruited to and they were just waiting for these staff to start in their new post.

We saw the Trust had introduced a variety of responses to the staffing issues such as using bank and agency workers and offering overtime pay to permanent staff. We were told bank staff had been deployed to make up staff numbers in some areas. Managers confirmed they had risk assessed and monitored the hours staff had worked. This was to ensure staff were not working excessive hours and getting tired which would affect patient care. Staff who had worked overtime confirmed they had been paid for this. Staff told us they would report concerns about staffing levels through the incident reporting system.

It is recognised there is little published guidance in relation to caseloads and staffing levels for community nurses. The Trust used a private company to help them develop a staffing model for community based services. The outputs of this work were sense checked with senior managers who had experience of working within the localities. This work ran alongside the Trust transformation programme which was designed to improve the quality and efficiency of community services.

The staffing model had been rolled out in the North and the Norwich localities. We saw how this worked in practice and spoke to staff and managers about the difference it was making to both themselves and their patients. The model set out the daily capacity available. All referrals for community services were triaged by a hub. The was a group of experienced staff who decided what the appropriate member and grade of staff should be allocated to each visit. The model built in break times and time for indirect activities such as records, team meetings, supervision and training and development. Each team member had a set level of activity each day. Although it was recognised by everyone in the Trust that there had been some initial difficulties with the system, staff were overwhelmingly positive about it and thought it would continue to develop further. One member of staff said, “It’s great because if I’m getting behind with my visits, the staff in the hub know and they can redirect my work.”

Mental Capacity Act

Staff had varying levels of understanding of the Mental Capacity Act (MCA) 2005. All of the staff we spoke with said the training on these subjects was very limited. Some remembered MCA was briefly mentioned during the safeguarding training sessions and they felt that was insufficient. We found staffs understanding of mental capacity and how this related to their work was patchy with therapists tending to have a better understanding than nursing staff. We found the speech and language therapy team at Norwich Hospital had a good understanding of the Mental Capacity Act. We did see records of how staff had documented that patients had given their consent for care and treatment.

Good

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.

Summary

The Trust's policies and clinical guidelines were based on the National Institute for Health and Care Excellence (NICE) guidelines. The Trust reviewed NICE clinical, technical and public health guidance through the Trusts governance processes. In the community, care and treatment was planned and delivered in a personalised and holistic way. A designated member of staff carried out an initial assessment. People had care plans which covered their health and social care needs. People using the service were supported to alleviate their pain appropriately. Staff said they had access to sufficient equipment to provide care and treatment.

Adult community services monitored the quality of the service they were providing through a range of different audits. Performance of services was monitored through a locality management structure which reported to various sub committees of the board and subsequently into the Trust board.

We saw examples of positive outcomes for people who used the service. The community intravenous (IV) therapy team had evidence of clear treatment pathways. Outcomes of IV treatment were constantly monitored by the microbiology service at the local acute NHS Trust.

Staff were appropriately qualified, skilled, experienced and competent to carry out their roles safely and effectively and in line with best practice. All the patients we spoke with in clinics and in patients' homes were complimentary about the ability of the community staff. There was effective multi-disciplinary team (MDT) working within the adult community service as well as with other health and social care providers.

The majority of the community staff said they felt well supported by their managers. New staff told underwent a competency based induction programme. Community staff told us they could access non mandatory professional development. The Trust employed 27 doctors and confirmed all of these were compliant with revalidation.

The Trust performed better in the 2013 NHS Staff Survey against questions regarding staff receiving job-relevant training, staff being appraised and staff receiving health and safety training.

Evidence based care and treatment

The Trust's policies and clinical guidelines were based on the National Institute for Health and Care Excellence (NICE) guidelines. For example, the Trust pressure ulcer prevention and management guidance reflected NICE (CG 179, Pressure ulcers: prevention and management of pressure ulcers). Clinical Guideline 169 on acute kidney injury was also incorporated into guidance for staff. We saw the speech and language therapy service used the professional standards set by the Royal College of Speech and Language Therapy. Staff knew where to find policies and local guidelines and we saw these were available on the intranet.

The Trust reviewed NICE clinical, technical and public health guidance through the Trusts governance processes. All new or updated guidance was risk assessed and was passed to the relevant service for it to be incorporated into guidance.

In the community, care and treatment was planned and delivered in a personalised and holistic way. A designated member of staff carried out an initial assessment. People had care plans which covered their health and social care needs.

Pain relief

People using the service were supported to alleviate their pain appropriately. We observed a community nurse following the prescribed medicine protocol for pain relief and administering the medicines prescribed through a syringe pump.

We noted a community matron promptly visited a patient when a call came through to the community centre where the nurses from the Coastal Integrated team (West locality) were based. A syringe pump had become blocked and the problem was resolved promptly.

Good

Are Community health services for adults effective?

Nutrition and hydration

We accompanied a community nurse who was visiting patients who suffered from diabetes. The patients required insulin injections before they had their meals. In the course of these visits the community nurse prompted each patient to maintain a healthy diet.

We observed a routine review of a patients care plans which had included a risk assessment using the Malnutrition Universal Screening Tool (MUST) score. The community nurse demonstrated how the MUST tool was used to assess the patient's nutritional needs. The nurse told us if they had concerns about a patient's nutritional and hydration needs the patient would be referred to a dietician or speech and language therapist via their GP.

During another home visit, we observed an occupational therapist asking a new patient if they were eating and drinking well. The therapist advised the patient and gave a booklet on hydration and nutrition.

Approach to monitoring quality and people's outcomes

Adult community services monitored the quality of the service they were providing through a range of different audits. Audits on leg ulcer care, assessment of the safe use of insulin, the management of the diabetic foot as well as a Trust wide audit of record keeping and management were undertaken in the last 12 months.

Performance of services was monitored through a locality management structure which reported to various sub committees of the board and subsequently into the Trust board.

The Trust monitored the responsiveness of the adult community service and monthly reports were provided to the Trust board regarding the number of patients with immediate health care needs seen within 4 hours of referral, the percentage of patients with urgent care needs seen within 24 hours of referral and the percentage of patients with routine care needs seen within 10 calendar days of referral.

We saw examples of positive outcomes for people who used the service. The community intravenous (IV) therapy team had evidence of clear treatment pathways. Outcomes of IV treatment were constantly monitored by the microbiology service at the local acute NHS Trust.

Competent staff

Staff were appropriately qualified, skilled, experienced and competent to carry out their roles safely and effectively and in line with best practice. All the patients we spoke with in clinics and in patients' homes were complimentary about the ability of the community staff.

The Trust has seen its overall appraisal rate drop below 90% to 66.6% in May 2014. The North locality had the lowest level of compliance with a rate of 56.44% whilst the South and West localities were slightly over 80%. Staffing levels had impacted on the rates and there was a plan in place to address the drop.

Staff said that their training needs had been identified at supervisions and appraisals. In 2013, the Trust set up a two day mandatory training programme for all staff. One member of staff said, "The two day training is more structured and organised." In addition to the mandatory training, staff were able to access online e-learning and there was a good library service to support staff with professional learning and development. Within the localities, mandatory training compliance was satisfactory.

We were shown the booking form entitled 'Learning and Development Passport 2013/2014' which listed the mandatory training. Topics included safeguarding, information governance, defibrillator training, resuscitation and anaphylaxis and investigation of incidents. Staff were able to request additional training to enhance their skills.

The majority of the community staff said they felt well supported by their managers and they had clinical supervision and annual appraisals.

New staff told underwent a competency based induction programme. This included a corporate induction as well as the opportunity to shadow staff. Different competencies were assessed by the staff members clinical supervisor and they were "signed off " when they were deemed competent. We saw evidence of these signed off competency checks. We spoke with a nurse who had just been appointed to work in the community nursing service.

The Trust provided over 400 training placements for student nurses and therapists across the organisation. The nurse told us they had only recently qualified but the Trust had support mechanisms in place to supervise and support them until they felt competent to work alone in the community.

Good

Are Community health services for adults effective?

Staff told us they had monthly team meetings and they had been encouraged to attend study days.

Community staff told us they could access non mandatory professional development. For example, additional training in leg ulcer care and treatment and training in end of life care. Staff told us they identified their training and development needs in their annual appraisal. None of the nursing or therapy staff we spoke with in the community service expressed any concerns about access to on-going professional development.

The Trust employed 27 (17.63 whole time equivalent) doctors and confirmed all of these were compliant with revalidation.

The results of the 2013 NHS Staff Survey were organised into 28 key findings. The Trust performed better against questions regarding staff receiving job-relevant training, staff being appraised and staff receiving health and safety training.

Use of equipment and facilities

Staff said they had access to sufficient equipment to provide care and treatment.

A community nurse showed us a diabetic blood glucose monitor that had been issued for the nurses to use. Each nurse was responsible for checking the monitor to ensure it was in good working order and was giving the correct readings. We observed the blood monitor being used for three patients who had diabetes. We saw the nurse followed the Trust policy and recorded the quality tests in a log book. This meant equipment was checked so it did not compromise patient safety.

We saw that urgent equipment, such as special mattresses for the prevention of pressure ulcers, would be delivered to a patient's home within 24 hours. Staff told us the Trust had changed their equipment supplier and there had been some "Teething," problems with the new service. Staff told us these were being "Ironed out," and they had been advised to report any problems with the service through the incident reporting system.

Multi-disciplinary working and coordination of care pathways

There was effective multi-disciplinary team (MDT) working within the adult community service as well as with other health and social care providers. The community matrons and other members of staff said they worked closely with other NHS Trusts, GPs, social services and voluntary organisations to ensure patients had the right care at the right time. We saw referrals to other agencies and discharge letters to GPs were appropriately completed.

Effective MDT working was clearly demonstrated with regard to the Hospital Home Care Service (West locality), where the community virtual team had worked closely with another NHS Trust and the local authority. A trained nurse from the virtual team visited the acute wards of the local acute NHS Trust and assessed patients suitable for early discharge using co-ordinated care pathways. This meant patients could be discharged home earlier whilst they still received appropriate care and treatment at home.

In the South and West Localities the community matrons assisted in caring for people with complex healthcare needs. They ensured that people had all the care they needed at home, including the input of GPs, community nurses, therapists and social care staff. This meant that people had their care delivered in a co-ordinated way without duplication of services.

The community nurses and therapists in the South locality told us they worked closely with other care co-ordinators funded by the local authority. These care co-ordinators had access to electronic information about the patients which meant they were able to cross reference with other care agencies to ensure patients received appropriate care at the right time.

Good

Are Community health services for adults caring?

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

Summary

People who used the service were treated with kindness and compassion. Almost all the people we spoke with were complimentary about the staff and the care and treatment they received. We contacted patients who used the community service by telephone. The vast majority of comments were positive about the care the patient received. We saw staff involved the patients they were caring for in their care planning.

Patients visiting the community outpatients and clinics felt respected and commented staff treated them with dignity. During a musculoskeletal clinic session held in the main building in the Aylsham clinic we noted that other patients in the waiting area could hear the interactions between other staff and patients who were receiving treatment. The waiting area was close to the treatment area and was separated by curtains only. This meant there was a risk that patients confidentiality or privacy and dignity may be compromised.

There is no current requirement for community Trusts to adopt the Family and Friends Test (FFT), but the Trust implemented the FFT in their community services in July 2013.

Between July 2013 and March 2014 the Trust reported an overall score of 79% positive responses, the lowest result being 72% in July 2013 and the highest being 86% in March 2014. This was a better score than the national target of 75%.

Compassionate care

People who used the service were treated with kindness and compassion. Almost all the people we spoke with were complimentary about the staff and the care and treatment they received.

We accompanied some community nurses and therapists when they visited people in their homes. People were very pleased to see each member of staff who visited them. One person said, "The nurse is very good. I get on well with all of them and they get on well with me."

We contacted patients who used the community service by telephone and the comments received included the following:

- "I am delighted with the service. I felt very supported. I would like to continue with continuity of staff."
- "Very good service. No concerns."
- "Absolutely fine. No concerns."
- "The staff don't always turn up on the day they had planned to visit."
- "Wonderful; a lot of support."
- "Excellent, highly delighted."
- "My only concern is the time; I never know what time they're coming, am or pm."
- A person and their relative expressed they were not happy when the wound dressings were changed. They felt they had not been consulted.
- "I am very happy with the service; no concerns."
- "The district nurses are very professional."
- "I am quite happy."

Dignity and respect

Patients visiting the community outpatients and clinics felt respected and commented staff treated them with dignity. We observed a screen being used before treatment began for a person in a leg ulcer clinic. In the IV clinic, we observed a member of staff having a telephone conversation with a patient in a polite and respectful way. We observed two patients being treated at the leg ulcer clinic in the community outpatients department at Dereham Hospital. One patient commented, "Staff treated me as a human being. Another patient said, "The staff always have a smile on their faces."

During a musculoskeletal clinic session held in the main building in the Aylsham clinic we noted that other patients in the waiting area could hear the interactions between other staff and patients who were receiving treatment. The waiting area was close to the treatment area and was separated by curtains only. This meant there was a risk that patients confidentiality or privacy and dignity may be compromised.

Comments received from people we met in their homes included:

- "The therapist is very nice and very efficient; the therapist covers everything and is reassuring, respectful and polite."

Good

Are Community health services for adults caring?

- "The nurses are very knowledgeable, competent and very friendly. I see different nurses but I am happy with all of them. They are always polite and they always keep me informed."
- "I see different nurses. They are all very nice and polite."
- "I get the same nurse every time. I prefer continuity of care. The care is very good." Their relative commented, "The nurse is brilliant."
- "Excellent service."
- "This team is fantastic."

Patient understanding and involvement

During a home visit, we observed how the therapist involved the patient they were assessed in their home environment in regard to the risk of falling. The person felt involved and reassured after the meeting and was very pleased with the information booklet she received.

In the IV clinic we noted each patient was provided with details of the service and their treatment plan. In addition to written consent, patient's consent was verbally sort before treatment began. We noted staff considered patients' needs and respected their preferred visiting times as long as they fitted in with their medication requirements as prescribed.

The Trust has a "Patient Experience and Involvement Strategy" in place that was developed with staff, patients and external organisations. There are three strategic themes in the strategy:

- Ensuring a systematic approach to capturing feedback
- Action for improvement
- Building meaningful and systematic engagement and involvement.

Emotional support

We accompanied a community nurse on a home visit to a patient with a leg ulcer. The nurse explained step by step as the old dressings were removed and replaced with new ones. the nurse made sure the patient was comfortable during the procedure. Later, the patient said, "The nurses are all friendly and they all do their best to make sure I am comfortable. I have had this done three times a week and I feel well supported."

Community staff also provided support to patients' relatives. We observed good support being provided to patients' relatives when we visited a patient with a community nurse. The patient was visited within minutes of the telephone call. This alleviated pain for the patient and reassured anxious relatives and carers.

Staff showed an understanding of the emotional needs of patients living in the community. They were aware of peoples home circumstances and the effect that living with a long term condition could have on people. We saw staff were empathetic in their approach to caring for their patients.

Promotion of self-care

Following a therapist assessment, a person commented, "I am so pleased with the way the staff explained things to me. I feel more confident in doing things for myself and have learnt how to stop myself from falling again. The therapist is very good and I am very pleased the therapist is coming back next week to see me."

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

Requires Improvement

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

Summary

The Trust monitored the responsiveness of the adult community service and while the majority of patients were getting a responsive service there were some concerns about waiting times within some areas of the adult community service. The waiting times to see a physiotherapist or an occupational therapist from the neurological service were 7 weeks for urgent cases and 17 weeks for non-urgent cases. At the time of our inspection, there were 63 patients on the waiting list.

Staff told us it was more difficult for patients to access the stroke pathway if they didn't start in it and we saw how this had proved difficult for one patients who had suffered a stroke.

The Trust achieved the 18 week referral to treatment target (RTT) with performance of 98% in July 2014. MSK physiotherapy, podiatry surgery and specialist nurses epilepsy management did not meet the target. We noted the Trust was working with the commissioners of the service to address many of these areas.

The Trust exceeded targets for the number of patients with immediate health care needs seen within 4 hours of referral (category A), the percentage of patients with urgent care needs seen within 24 hours of referral (category B) and the percentage of patients with routine care needs seen within 10 calendar days of referral (category C).

People received personalised care in the community. Staff delivered care and treatment that focused on people's needs, preferences and wishes. People's health and independence had been promoted. The Trust had access to an interpreting service. Staff knew how to access interpreting services

We observed the community nursing and therapist teams working together to ensure all patients on the daily list were visited as planned. The community staff confirmed patients were told the day of the visit but were not given a time. Some patients and staff told us they would like to see more continuity of nursing care . Some patients commented that they would prefer to be told if their home visit would be AM or PM.

The Trust had services to promote safe discharge home from hospital as well as to promote independence of people in their homes and avoid hospital admissions. The Hospital at Home service was an example of this.

Service planning and delivery to meet the needs of different people

People received personalised care in the community. Staff delivered care and treatment that focused on people's needs, preferences and wishes. People's health and independence had been promoted.

Community staff also provided support to patients' relatives. We observed good support being provided to patients' relatives when we visited a patient with a community nurse.

We saw information leaflets available in clinic waiting areas. Generally, there were adequate facilities for patients in clinics, including wheelchair access to toilet facilities. There were clear signs at the entrances to clinics to indicate which clinics were running as well as the named staff members operating the clinics.

Community nursing staff we spoke with all told us they worked well together as a team to visit all of their patients on a daily basis. We attended a district nursing team handover meeting in the North locality which was held every afternoon to update the patient list for the following mornings visits. We observed how staff worked together to visit their patients every day. In situations where a member of staff had not been able to complete their morning visits other team members had helped out in the afternoon. Two therapists working in the West locality expressed how they planned their visits together and said the system worked very well for them. This meant patients were visited as planned and their needs were met.

The Trust had access to an interpreting service. Staff knew how to access interpreting services.

Access to the right care at the right time

The community team provided a number of specialist services to meet the needs of the local community. They

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

Requires Improvement

cared for patients suffering from stroke and epilepsy, neurological patients and people with long term conditions, as well as frail elderly people prone to falls and patients at the end of life.

We observed the community nursing and therapist teams working together to ensure all patients on the daily list were visited as planned. The community staff confirmed patients were told the day of the visit but were not given a time. One patient felt it would be good if they were told whether the visit would be in the morning or the afternoon. Some patients and staff told us they would like more continuity of care. We saw the Trust tried to offer continuity as much as possible and there was a commitment to do this. In Norwich we spoke with three community nursing staff who expressed concern about the new ways of working that had recently been introduced as part of the Trust transformation programme. The nurses were concerned that patients were no longer receiving continuity of care as different nurses were now visiting patients all the time. Senior nurses confirmed there had been some issues with continuity when the new model was introduced but they working hard to address this. We spoke with staff who had been using this new model for a longer period of time within the North locality. They told us that continuity of care was not a problem and the initial difficulties had been ironed out. Although patients did not get to the see the same nurse for every visit, the aim was to provide as much continuity for patients as possible. There was a recognition that this was in the patients and the staffs best interest.

We saw a patient who had suffered a stroke whilst out of the county. Because the patient did not enter into the stroke pathway at the time of diagnosis they experienced delays getting rehabilitation following their return home to Norfolk. Staff told us it was more difficult for patients to access the stroke pathway if they didn't start in it. This meant services were not equitable because it depended on where the patient suffered their stroke.

The Trust monitored the responsiveness of the adult community service and monthly reports were provided to the Trust board regarding the number of patients with immediate health care needs seen within 4 hours of referral (category A), the percentage of patients with urgent care needs seen within 24 hours of referral (category B) and the percentage of patients with routine care needs seen within 10 calendar days of referral (category C). The results for the August 2014 access targets were 98% for category A, 92.3% for category B and 95.7% for category C.

The access scores were higher than the Trusts targets. This meant the vast majority of patients were getting a responsive service. However, there were some concerns with waiting times for appointments for some outpatients' and specialist clinics due to inadequate staffing numbers, unfilled vacancies and increased demands and workloads as in the following services:

- Community Neurology Service/Clinic, St James Clinic, Kings Lynn (West Locality). The neurological team based at St James Clinic, Kings Lynn consisted of 16 staff of different disciplines, including specialist nurses, therapists and psychologists. The staff conducted mainly home visits and some clinics. Due to sickness the team was short of one full time physiotherapist and bank staff had been deployed but they were not always available. We were told the waiting times to see a physiotherapist, speech and language therapist or an occupational therapist were 7 weeks for urgent cases and 17 weeks for non-urgent cases. At the time of our inspection, there were 63 patients on the waiting list. Mitigating actions had been put in place, such as increasing the proportion of patients seen in clinic rather than their own home, training of assistant practitioners to enable them to hold a communication caseload. Letters were being sent to keep GP's and other referrers informed of the delays.
- Neurology Service (South Locality). The Neurology Clinic in the South locality was managed by two specialist neurology nurses, supported by the hospital consultant and four GPs. Patients and GPs were complimentary about the staff and the service they managed. However, the specialist nurses had large caseloads totalling 880 patients and the waiting time had increased from 6 months to 8 months for patients to be reviewed. The initial referral was 6 to 8 weeks.
- Family Planning Service/Clinic (West Locality). The family planning service based at St James clinic, Kings Lynn, had a two month waiting time for the insertion of a coil.
- Blood Clinic. The Blood Clinic based at Norwich Community Hospital was managed by two phlebotomists. We were told the waiting time for blood tests was around 45 minutes. Two patients told us they

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

Requires Improvement

thought the waiting times in the blood clinic were too long and they felt the opening times were limited. The clinic was open until 14:00 hours. We observed three patients arrive at Norwich Hospital shortly after 14:00hrs for blood tests and were told the clinic was closed. They said their GP practice had not told them the clinic was only available until 14:00hrs.

- Podiatry Service (Norwich and West Locality). The Podiatry service had been taking referrals from GP's and other providers as well as from patients themselves. Patients had been complimentary about the Podiatry service. However we were told the waiting time ranged from 5 weeks to 16 weeks, particularly in the Norwich locality. Recently the waiting time had been over 18 weeks due to the long term sickness of a senior medical member of staff. This problem was being addressed by referring some patients to an orthopaedic surgeon in a nearby acute Trust hospital. In addition, the Trust had offered clinic staff extended working hours and overtime pay to address the waiting time problem. There were plans to employ more nurses. This service was subject to a contract query notice by the Norfolk Clinical Commissioning groups. The Trust had a remedial action plan in place to address the backlog of patients.

The Trust achieved the 18 week referral to treatment target (RTT) with performance of 98% in July 2014. RTT is a performance measure used in the NHS to measure the time taken from when the patient was referred to treatment to the treatment being commenced. The Trust monitored its performance and presented a monthly Integrated Performance report to the Trust board. In July, all services achieved 100% of RTT times with the exception of the following adult community services: Musculoskeletal (MSK) Physiotherapy 94.7%, Podiatry surgery 80.4% Specialist nurses epilepsy management 98.4%.

The Trust had action plans in place to address this performance and these were monitored through the Trusts governance arrangements as well as through the clinical commissioning group. We did not find evidence that the Trust monitored waiting times for services that were not monitored through national RTT targets.

Discharge, referral and transition arrangements

The Trust had services to promote safe discharge home from hospital as well as to promote independence of people in their homes and avoid hospital admissions. The Hospital at Home service was an example of this.

Complaints handling (for this service) and learning from feedback

During the reporting period December 2013 to May 2014, the Trust received a total of 119 complaints. We saw evidence that all complaints were acknowledged within three days and responded to within 25 days which was in line with national guidance on complaints handling.

The Trust monitored complaints and reported performance to the Quality Risk and Assurance Committee and then to the Trust board.

We were told concerns and suggestions in customer satisfaction surveys were taken seriously and appropriate action had been taken to address issues raised. For example, as a result of a survey, improved signage had been implemented in outpatients' departments and clinics.

Complaints/compliments/feedback forms were displayed and available in most community clinics and outpatients' waiting areas.

Staff confirmed all investigated complaints and lessons learnt had been cascaded down and shared at local team meetings. Staff in the various community teams we visited said they had not received any formal complaints. Staff had developed a good rapport with people using the service and their relatives so that any problems could be addressed promptly and this had avoided the need for people to complain. Practically all the people we spoke with were complimentary about the staff and the care provided.

Good

Are Community health services 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.

Summary

There was a Trust wide Quality Improvement Strategy in place which set out the Trusts vision and approach to quality for 1014-2016. We saw this was displayed in many of the community clinics and outpatient departments we visited. In addition there was also an Organisational Development Strategy in place that was developed from engagement of staff across the Trust.

The Trust had been through a transformation programme for community services and staff told us they had been involved in the consultation. This had been a major change for many staff. Staff told us that initially there was anxiety amongst staff about the programme and it had affected morale. In the North locality we found staff were positive about the transformation programme and could see the benefits that it had brought. Many staff told us the that although there had been difficulties, the Trust had listened and responded to these and they thought communication between staff and senior managers and Trust executives had improved. There were some staff who did not think their views had been listened to.

Each locality had local clinical governance meetings. There was dedicated support within each of the localities for clinical governance. Local risk registers were maintained and risks were placed on the Trust-wide risk register. Some risks were not reviewed in a timely manner and had been on the register for some time. This was a Trust wide issue and there were plans in place to review and improve the quality of all risk registers.

There were clear line management arrangements in place. Staff we spoke with were committed to providing good quality care and were proud of their work. Every month the Trust board heard about a patient's experience at the start of their board meeting.

The results of the 2013 NHS Staff Survey showed the Trust has performed better than the national average against five questions and worse than the national average against five questions.

Vision and strategy for this service

The Trust had an overall strategy which generated service specific strategies and plans. The clinical vision behind services recognised that the Trust is about home, families and connecting communities. It recognised that integration of care is key. For frail, elderly adults, the Trusts vision was to ensure the majority of care was delivered in the patient's home. If additional care was required, there was number of 'community hubs' where patients could access community based diagnostic tests and assessments. This strategy informs the transformation programme.

The Trust had been through a transformation programme for community services and staff told us they had been involved in the consultation. As part of the Trust transformation programme over 2000 staff were communicated with and involved in planning of transformation, this had been a major change for many staff. To help support the transformation and the quality and organisational development work, 40 "Change Champions," had been organised who were communicating 3 key messages to staff every 2 weeks. Staff were able to tell us about these messages.

The Trust values had recently been refreshed and were formally signed off at an extraordinary Board meeting in June 2014. The values were in the process of being rolled out across the Trust through promotion materials, training at Induction, mandatory training and leadership training. We found some staff knew about these values.

Guidance, risk management and quality measurement

Each locality had local clinical governance meetings. There was dedicated support within localities for clinical governance. Local risk registers were maintained and risks were placed on the Trust-wide risk register. Some risks were not reviewed in a timely manner and had been on the register for some time. This was a Trust wide issue and it was being addressed.

The service used an Early Warning Trigger Tool (EWTT) as a method of identifying risks within teams and services. The tool assessed metrics such as staffing levels, wait times and

Good

Are Community health services for adults well-led?

management arrangements. The tool should be completed by all teams and when the score reached a defined threshold, enhanced scrutiny was put into place. Within the Trust, any team/service rated as red has to have an action plan in place of how risks will be mitigated against.

In July there were 85 teams./services who submitted their EWTT self-assessment. Of these 63 were rated as green, 11 amber and 11 were rated as red. Of the 11 red rated teams, eight related to adult community services.

The Trust has seen its overall appraisal rate drop below 90% to 66.6% in May 2014. The North locality had the lowest level of compliance with a rate of 56.44% whilst the South and West localities were slightly over 80%. Staffing levels had impacted on the rates and there was a plan in place to address the drop.

The Trust's sickness absence rate for January – March 2014 was 4.33%, which was slightly lower than the figure of 4.57% for community health Trusts nationwide for this period. The Trust did not monitor the sickness/absence rate by service type because it monitored performance by locality. The rates of sickness/absence in the adult community and inpatient teams were highest in the Norwich and West localities, 5.58% and 5.27% respectively.

Leadership of this service

Staff told us that initially there was anxiety amongst staff about the transformation programme and it had affected morale. In the North locality we found staff were positive about the programme and could see the benefits that it had brought. Many staff told us the that although there had been difficulties, the Trust had listened and responded to these and they thought communication between staff and senior managers and Trust executives had improved. There were some staff who did not think their views had been listened to. We saw the Trust had been through an extensive consultation with staff.

There were clear line management arrangements. Staff knew the modern matron for their locality, the community matrons, the clinical operations managers and the general managers for the directorate. Staff attended monthly team meetings which was the forum for senior managers to cascade information from the board to frontline staff.

Most staff said there was effective communication and leadership from their line managers and staff felt well supported by them. They told us they could approach their managers comfortably and ask about anything. Staff received regular updates about Trust developments through emails and Trust bulletins. Some staff reported they did not always read them while others told them they found them very useful.

Staff felt confident and comfortable to speak with their line managers and senior managers if they had issues. Staff felt well supported by their line managers and some felt they had been listened to when they had raised concerns about staffing levels. Several staff commented they were inspired when one of the assistant directors spent a day out with a community staff member when concerns about staffing levels had been raised. Since then new staff had been recruited.

Culture within this service

Staff we spoke with were committed to providing good quality care and were proud of their work. There was a culture of collective responsibility and applying the multidisciplinary approach to helping teams to ensure positive outcomes for patients.

The Trust supported the Nursing Times Speak Out Safely campaign. The Trust had done this because they wanted every member of our staff to feel able to raise concerns about wrongdoing or poor practice. There was a whistle blowing policy in place and staff were able to tell us about this.

Public and staff engagement

Every month the Trust board heard about a patient's experience at the start of their board meeting. A patient or carer is supported by the Patient Experience and Involvement team to share their experiences of their care from the Trust and how this connected with other services they may have experienced. Patients and carers could directly tell the board about where care has been good and where improvements can be made. Actions arising were followed up by the Director of Nursing Quality and Operations.

The results of the 2013 NHS Staff Survey showed the Trust has performed better than the national average against five questions and worse than the national average against five questions. The Trust performed better against questions regarding staff feeling their role made a difference to patients, effective team working, staff receiving job-relevant training, staff being appraised and staff receiving health and safety training. The Trust performed worse than average against five questions – the percentage of staff

Good

Are Community health services for adults well-led?

experiencing physical violence from patients, staff experiencing harassment from staff, staff feeling under pressure to work when unwell, staff reporting good communication with management and staff recommending the Trust as a place to work. The Trust's performance has deteriorated against the first two questions.

Innovation, improvement and sustainability

The Trust was an integrated provider of health and social care working with Norfolk County Council. Following a section 75 agreement of the National Health Service Act 2006, the Trust worked with Norfolk County Council to provide nurses and therapists to work with social workers in an integrated learning disability service. A further section 75 agreement for the provision of a joint management structure was approved on October 1 2014. This meant there would be two executive positions, a director of Integrated Care and a Director of Nursing Quality. The post holders will take responsibility for all health and social care (excluding children's services) across the whole of the Norfolk's health and social care system. It will see the integration of community nursing, therapy and social work. The post holders with be employed by the Trust but will report jointly to the Chief Executive as well as the Director of Community Services at Norfolk County Council. Health and social care professionals will be co-located in teams and will share access to health and social care records as well as sharing referral processes and case management.

On the whole both managers and staff we spoke with were positive about the reorganisation of the services and methodology changes taking place within the Trust, through optimisation and transformation. Staff felt these changes would help eradicate inconsistencies in practices throughout the four localities.

Staff we spoke with felt the new booking system, using a single point of contact helped control the caseloads for the community staff. The electronic care planning through this new system ensured consistency in updating patients care pathways, care plans, treatment and progress notes. This ensured all staff were able to access updated information and meant patients received co-ordinated care and treatment. The system was being rolled out across the whole of the Trust in the coming months.

The community continence team had been encouraged by the Trust to look at new initiatives such as the need to promote the continence service as a treatment service and not a pad provision service. The Trust was in the process of rewriting the policy for the provision of pads.

The Trust was involved in initiatives with other providers aimed at maintaining the independence of people at home and avoiding hospital admission. One of the initiatives was the "Hospital Care at Home," service in the West locality.