South Tyneside NHS Foundation Trust

RE9

Community health services for adults

Quality Report

Tel: 0191 404 1000
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Date of inspection visit: 5-8 May 2015
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RE9GF	Palmer Community Hospital		
RE9GA	South Tyneside District Hospital		
RE9X2	Blaydon Primary Care Centre		
RE9GA	South Tyneside District Hospital	Carr Hill Clinic	
RE9GA	South Tyneside District Hospital	Bensham Hospital	
RE9Y3	Monkwearmouth Health Centre		
RE9GA	South Tyneside District Hospital	Pallion Health Centre	
RE9GA	South Tyneside District Hospital	Flagg Court Health Centre	
RE9GA	South Tyneside District Hospital	Clarendon	
RE906	Elmville Short Break		

This report describes our judgement of the quality of care provided within this core service by South Tyneside NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by South Tyneside NHS Foundation Trust and these are brought together to inform our overall judgement of South Tyneside NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good l

Overall community health services for adults were good, with caring rated as outstanding. Incidents were reported across teams and learning from incidents was identified. The safeguarding policy was understood by staff and used as part of their practice. Equipment was used safely. The service had infection prevention and control policies in place. Staffing levels were sufficient in most areas to meet current demand. The service had a lone working policy in place and implemented procedures to reduce the risks to staff working alone. The service had plans in place to respond to major incidents.

The service undertook a range of audits to improve performance and ensure patient safety. Clinical governance meetings were held regularly. The service had introduced the Friends and Family Test (FFT) patient satisfaction survey in January 2015. The service was in the process of introducing integrated care an innovative multi-disciplinary practice model.

Staff understood their individual roles and responsibilities. Recognised assessment tools were used for the assessment, planning, and review of patient care and treatment. There was good multi-disciplinary working and effective handover and multi-disciplinary team meetings. Staff consistently told us they had good links, and access to, a wide range of other services. Staff felt the executive team were approachable; but the community teams were attached to different divisions. Managers and team leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was effective.

Patients and their relatives were truly respected and valued as individuals and were empowered as partners in their care. Feedback from patients and their families was consistently positive about the way staff treated them. Patients thought staff went the extra mile in providing care, treatment, and support.There was a strong person-centred culture. Staff were considerate and empathetic towards patients and their relatives. Staff respected patient confidentiality in written records and other communications. The approach staff used in the home setting demonstrated compassion and consideration for the patient.

Patients could access community health services promptly. Discharge liaison arrangements between the acute hospital and community settings were in place. Arrangements were in place for the training of clinical staff in caring for patients living with dementia. Staff were aware of complaints patients had made, and what was done to resolve complaints. Following the investigation of complaints actions were identified. This was discussed with patients and actions were monitored to completion.

The service had governance and risk processes in place. The service actively maintained a risk register and responded to identified risks; long-term staff sickness was not identified on the register. The service planned for seasonal fluctuations in demand. Managers and staff told us they felt integrated care provided a clear vision for community services. The service had a strategy of improvement and changes to service delivery.

Summary of findings

Background to the service

Background to the service

Community services for adults are part of the South Tyneside NHS Foundation Trust. The trust provides a variety of community services in South Tyneside, Gateshead, and Sunderland.

Community services for adults include district nursing, cardiology, eye and diabetic screening clinics, podiatry and a range of other services such as planned care, intermediate care, learning disabilities, and urgent care.

District nursing services in Gateshead, South Tyneside and Sunderland, provide care predominantly to housebound patients, but also in clinics in GP settings. The district nursing teams are led by a qualified district nurse (a registered nurse with additional qualifications). Teams include registered nurses (RGN) and health care assistants (HCA). The district nurse teams operate a single point of contact (SPOC) for all referrals that are made into the service.

Community services for adults operate a 24/7 rapid response and out of hours service in South Tyneside and Gateshead. These are nurse led teams, providing support to patients at home to avoid unnecessary hospital admissions.

Community matrons also operate within the community services for adults' structure. Community matrons are a team of nurses working in Sunderland, Gateshead and South Tyneside who provide care for adults with more than one complex, long term condition, such as: diabetes, respiratory disease, or heart disease. Community matrons visit people in their own homes and develop personalised care plans. Community matrons' co-ordinate care with other health and social care professionals. By doing this they can prevent unnecessary admission or attendance at hospital, they work with the acute hospital to support discharge home.

During the inspection we visited the following community health services for adults:

Out of hours service South Tyneside ACT, Palmer Community Hospital Gateshead UCT, Bensham Hospital

District nursing service Blaydon Primary Care Centre Palmer Community Hospital Monkwearmouth Health Centre Pallion Health Centre

Community matrons Palmer Community Hospital

Leg ulcer clinic Carr Hill Clinic

Podiatry clinic Blaydon Primary Care Centre

Urgent care team Leechmere Centre

Eye/diabetic screening clinic Flagg Court Health Centre

Cardiology Clarendon

Learning disability service Elmville short-break service

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Chair: Trish Rowson, Director of Nursing – Quality and Safety, University Hospitals of North Midlands NHS Trust.

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Health Visitors, District Nurses, Physiotherapists, Occupational Therapists, Community Matrons, Dentist and Expert by Experience (people who had used a serice or the carer of someone using a service).

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive acute and community health services inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 5 to 8 May 2015.

During this inspection we met with in excess of 110 managers and staff representing a range of roles and seniority. We included qualified nursing staff, specialist nurses, allied health professionals (physiotherapists, cardiologists and podiatrists), health care support workers, team leaders and managers. Interviews were conducted on a one to one basis, in small groups of two or three staff within a service, or in group discussions arranged as focus groups.

Inspectors spoke with more than 20 patients in a number of settings. We visited clinics, and we accompanied district nurses visiting patients receiving care at home to observe care, as well as talking with patients and their relatives about their experience of the service. We spoke with some patients by telephone to ask their views on their care and treatment.

What people who use the provider say

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

We viewed the podiatry service FFT results for the first quarter, January 2015. This demonstrated that 79.3% of patients, who completed the test, were extremely likely to recommend the podiatry clinic to their friends or family, with 0% of patients responding that they were either unlikely or extremely unlikely to recommend the clinic.

We viewed the results of the learning disability community nursing service FFT from February 2015. Patients had been provided with an easy read questionnaire. 95% of patients who completed the questionnaire indicated that they would recommend the service to their friends or family. None of the patients who responded to the survey gave a negative response.

Good practice

Outstanding practice

- The district nurse teams operated a single point of contact for all referrals that were made into the service to ensure patients received the right care from the right nurse at the right time.

Summary of findings

- Patients and their relatives were truly respected and valued as individuals and were empowered as partners in their care. Feedback from patients and their families was consistently positive about the way staff treated them. Patients thought staff went the extra mile in providing care, treatment, and support.
- Community health services for adults had a 24 hour, seven days a week, rapid response team. The multi-disciplinary team had a range of skills to support patients at home. These included nurses, physiotherapists, social worker, and care support staff. The service provided services to patients at home, as well as in nursing and residential care homes to help them recover from illness, and provided support to avoid unnecessary hospital admissions.
- The district nursing teams electronic system, HYDRA, had enabled teams to manage patient referrals and plan appointments for home visits. The introduction of HYDRA had resulted in improved efficiency in district nursing teams by reducing missed or duplicated visits and delays in treatment.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider should take to improve:

- The trust should review arrangements for clinical supervision in district nursing teams.
- The trust should ensure staff mandatory training is updated promptly and staff training records are updated.
- The trust should ensure community health services for adults equipment is serviced regularly and recorded in the medical device register.
- The trust should ensure audit action plans are updated promptly when action plans have been implemented.

South Tyneside NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Incidents were consistently reported across teams. Learning was identified from the investigation of incidents. Policy relating to the duty of candour requirement was in place. A safeguarding policy was in place. This was understood by staff and used as part of their practice. Equipment was used safely. The service had infection prevention and control policies in place. Staff had received training in medicine management and followed guidance and procedures.

The service was proactive in responding to identified risks and maintained a risk register. Patient risk assessments were fully completed. The service managed foreseeable risks and planned for changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather. The service had contingency plans in place to respond to major incidents.

Staffing levels were sufficient in most areas. For some community services teams, there had been an increase in the levels of staff sickness although we found the risks associated with this were managed.

Patient's records, risk assessments, and care plans were completed and information was up to date.

Detailed findings

Safety performance

- Between December 2013 and November 2014 the trust reported a total of 95 serious incidents in hospitals or other settings in the community, including in patients' homes; 33 of these were grade three pressure ulcers.
- Safety alerts were sent to clinical leads by email. The alerts were reviewed by clinical leads for their relevance then disseminated to staff by email or discussed at team meetings. Safety alerts were available to staff in team folders on the trust's shared computer drive.

Incident reporting, learning and improvement

- Between December 2013 and November 2014 the trust reported a total of 95 serious incidents in hospitals or other settings in the community, including in patients' homes; 33 of these were grade three pressure ulcers.

Good

Are services safe?

- The community adults' service used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately.
- We reviewed a sample of investigation reports submitted by the service. Root cause analysis (RCA) was completed as part of the investigation of incidents. RCA's identified learning from incidents and lessons learned from incidents were shared across teams. An action plan was developed as a result of RCA's. Staff told us that RCA's were completed for pressure sores of grade three and above.
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed that they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within community services.
- A standard agenda was used for staff team meetings. Learning from incidents was discussed and disseminated to staff at team meetings.
- All patients with pressure ulcers were recorded on the electronic reporting system. Staff told us the system was used to monitor incidence of pressure ulcers across teams.
- Safety alerts were sent to clinical leads by email. The alerts were reviewed by clinical leads for their relevance then disseminated to staff by email or discussed at team meetings. Safety alerts were available to staff in team folders on the trust's shared computer drive.

Safeguarding

- The service had a safeguarding policy. Staff were able to explain their understanding of the policy and how they used this as part of their practice.
- Staff received training in safeguarding as part of their mandatory training. All community staff received safeguarding adults and children level one training. All clinical staff were trained to level two. Staff received further training updates at a level appropriate to their area of work. We reviewed evidence that compliance with mandatory training was between 80 to 85% in some community teams. Staff who had not updated mandatory training were booked onto courses.
- Staff we spoke with were able to describe the categories of abuse and how they would report potential safeguarding issues. Issues were reported to the safeguarding lead for further investigation. If safeguarding concerns were identified the clinical lead was invited to attend the strategy meeting. Learning from safeguarding investigations was shared at team meetings and across the service where appropriate.
- Patients we spoke with told us they felt safe and expressed confidence in the staff that worked with them.
- Information about safeguarding for patients in the community including contact information for the single point of contact (SPOC) was included in patients home based records. The trust's website included contact details for the safeguarding adults unit and advice for patients and carers.

Medicines

- Medicines were observed to be prescribed, supplied, stored, and administered appropriately.
- Controlled drugs were handled appropriately, with the involvement of the GP as necessary.
- Training in the administration of medicines was undertaken by appropriate staff groups. All case holding district nurses were trained in community formulary. Community matrons were trained in prescribing and advanced practice clinical skills.
- We reviewed 11 medicine administration records and found these were up to date and in order. Medication errors were reported as incidents and were followed up to identify learning.

Environment and equipment

- We found there were adequate stocks of equipment. Patients were offered a choice for some items of equipment. In urgent circumstances, equipment could be supplied to the patient on the same day by the equipment service. Patients were informed by the equipment service if they were unable to deliver within timescales. A limited stock of equipment was available for out of hours emergencies.
- Maintenance and procurement of replacement equipment was planned by liaison with the trust's equipment services team. The equipment services team was responsible for the maintenance of equipment.
- Each medical device was recorded on the medical device register for each team. This indicated the date it was due for service and electrical testing. We saw that devices had been serviced in accordance with the

registered date for servicing. However, we noted that some podiatry devices had not been serviced in accordance with the medical device register. For example, the Doppler at Blaydon primary care centre did not have a service due date in the medical device register. Podiatry staff we spoke with told us they couldn't confirm if the equipment had been serviced.

- District nursing teams had a named link nurse for medical devices. The link nurse was responsible for sharing medical device alerts at team meetings and monitoring the medical device register to ensure equipment was serviced regularly.

Quality of records

- We reviewed 14 paper based patient records during our observations of patient care. We found initial assessments, risk assessments, care plans, reviews, and consent documentation were completed appropriately. Referrals to the SPOC were completed electronically. Actions taken were recorded on the electronic system.
- Copies of patients paper based records were maintained in the community bases. A set of notes was kept in patients' homes; these included essential contact numbers, medication records, care plans and daily notes.
- We viewed local staff training records across community services, and found that most staff training in information governance was up to date.
- We observed community based staff completing and updating records when they visited patients at home. The daily records we viewed in patients' homes were up to date.
- Staff told us that the service did not have direct access to GP records systems. Information from GP's was faxed to community services. Staff told us the trust was transitioning to EMIS a computerised records management system for integrated community services. Arrangements were in place for staff to receive training in the new records management system. Staff said negotiations were in progress with GP's for community nurses to enable information sharing with GP's using EMIS.

Cleanliness, infection control and hygiene

- The service had infection prevention and control policies in place.
- We observed staff during home visits and in clinic settings. Staff demonstrated a good understanding of infection prevention and control. We observed staff following trust guidelines in particular hand hygiene and wearing clothes bare below the elbow. We saw staff using personal protective equipment (PPE), gloves and aprons appropriately. We saw equipment being cleaned after use.
- The community locations we visited were visibly clean with evidence of regular adherence to cleaning schedules. Clinic environments we visited were visibly clean and tidy and appropriate sharps boxes were available.
- Staff received mandatory training in infection control and prevention.
- Staff told us that each community nursing team included an infection control link nurse. The link nurse's responsibilities included attending infection control meetings and providing feedback at team meetings. The infection control link nurse also took the lead with infection control audits. We saw that hand hygiene audits were completed monthly. Community nursing had achieved 100% compliance in hand hygiene.
- Information about infection control was displayed on staff notice boards and included guidance about correct waste disposal, hand hygiene techniques, and methicillin-resistant staphylococcus aureus (MRSA) screening.

Mandatory training

- We reviewed the trust's records for training which were broken down by service and location. The information showed the number of staff who had completed mandatory training by type of training. We reviewed evidence that compliance with mandatory training was 80% to 100% across community services. For example, the 24/7 rapid response team had achieved 100% in all mandatory training updates.
- We reviewed local mandatory training records. We found that training had been undertaken in most instances, or arrangements had been made to attend training. Staff were supported to attend mandatory training within their working hours. However, a member of the community nursing team and a member of the podiatry team told us there had been occasions when they had cancelled their attendance at mandatory training due to demands on the service.

Good

Are services safe?

- Staff we spoke with explained they were expected to attend the acute hospital for some parts of their mandatory training, but this was often impractical for community based staff.
- Staff told us major incident awareness training for community staff was delivered through a combination of e-learning and discussion in team meetings. Staff we spoke with told us they had not been involved in a rehearsal for dealing with a major incident.
- Staff across the service told us they were not always able to be released for training when teams were short staffed. This could hinder some staff being able to achieve the required level of competency for their role.

Assessing and responding to patient risk

- The service maintained a risk register. The service's risk register was monitored by the clinical commissioning group (CCG). However, a number of staff reported long-term staff sickness as posing a risk during the winter months. This was not included in the service's risk register. Staff in Sunderland and Gateshead told us that winter pressures were a risk due to long-term staff sickness absence and a combination of the locality having patients with long-term needs. The manager told us that long-term staff sickness was covered on the risk register under generic staffing risks. However, the risk register action plan was not specific on how the service was meeting the risks posed by long-term staff sickness absence. We saw that the service was addressing long-term sickness by communicating with absent staff and offering part-time staff in community teams extra hours.
- Community based staff we spoke with were able to demonstrate awareness of the key risks to patients. For example, risks of falls and pressure damage.
- Depending on risks identified to patients staff were aware of how to arrange further support by referral for specialist assessment or supply of additional equipment.
- We viewed nine patient records during home visits. As part of our review of patient records, we found that risk assessments were fully completed for each patient, these included skin integrity, nutrition, pain assessment, falls risks, and activities of daily living.
- The risk of patients acquiring pressure ulcers was identified as a primary concern for community patients. Pressure ulcers assessed as a severity of grade three or above were referred for investigation as a serious incident and a RCA was undertaken. The RCA was reviewed at a monthly pressure ulcer review panel, where an action plan was formulated. Following the panel, actions were implemented by the clinical team involved; organisational actions were allocated to appropriate strategic leads. Action plan outcomes were monitored by the panel.
- Themes and lessons learned from RCA panels were communicated to the trust's developing excellence education and learning group (DEEAL). The information was also shared with the executive board/ patient safety committee and formed part of the trust's annual report.
- Patients at risk of falls had access to the service's community falls team. We saw evidence of the community falls team in Sunderland achieving an 81 per cent reduction in the total number of falls among patients completing its rehabilitation programme, with 69 per cent going on to have no further falls.

Staffing levels and caseload

- The district nursing and specialist nursing teams had introduced an electronic rostering tool (e-rostering) in April 2015. The e-rostering tool was used to plan staff workload. Managers we spoke with were positive about e-rostering. Managers explained the tool allowed them to achieve required staffing levels, whilst reflecting teams' skill mix, miles travelled, and complexity of patient needs.
- Team managers we spoke with told us they could monitor each call for each day and ensure it was was allocated via the e-rostering system. Managers explained and demonstrated how the e-rostering system was used to ensure patient safety was not compromised.
- Managers told us that the e-rostering tool adequately supported the planning of staff cover arrangements in the event of staff being absent. The e-roster had a facility that sent information to the bank staff system and bank staff could then be rostered in to cover any gaps in staffing.
- The service used an NHS bank staff service to obtain temporary staff for other peaks in district nursing workload, subject to staff being available at the appropriate level of competence. New bank or agency staff received an induction for a week and were invited to shadow an experienced member of staff. Bank and agency staff could access policies and procedures via the trust's intranet.

Good

Are services safe?

- Specialist nursing teams we spoke with informed us that staffing levels were sufficient for current contact and activity levels, although increases in referrals as well as the complexity of cases, required regular review. Caseloads for district nurses was approximately 150.
- Staff absence figures for community nursing teams across South Tyneside from January to March 2015 was 7% on average. The vacancy rate for community nursing teams across South Tyneside from June 2014 to March 2015 was 3% on average.

Managing anticipated risks

- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather. Staff told us that the HYDRA system identified vulnerable patients and allocated calls on the basis of care and complexity and that this ensured the needs of vulnerable and highly dependent patients were met during the winter and during heatwaves.
- The service had a winter plan in place. This included community staff having access to 4x4 cars to maintain staff safety and to support access to patients in all community settings; the plan also provided telephone access to specialist services, which would provide advice to patients and staff during adverse weather. Planning included using staff that may be snowbound to visit patients in the area where they lived who were within walking distance.
- Staff told us the HYDRA system had improved patient access and reduced the amount of paperwork district nurses had to complete. Referrals from G.P's and hospitals were immediately logged onto HYDRA, which generated a list allocating patient visits to district nurses. Patients who were at risk of deteriorating were identified on HYDRA, as well as at district nurse hand-overs.
- The rapid response service demonstrated how the patients' record system carried alerts for staff to identify patients who were high risk.
- Oxygen users were provided with back up cylinders. Staff told us in the event of a power cut the company who provided the oxygen cylinder would link with the energy provider to ensure patients who used oxygen were prioritised in regards to restoring power supplies.

Good

Are services effective?

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

Summary

The community adults' service used National Institute of Clinical Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support care and treatment for patients. Staff understood their individual roles and responsibilities in the delivery of evidence based care. Nutrition and hydration assessments were completed appropriately. Patients' pain was managed appropriately.

Audits of community health services for adults were undertaken to review the outcomes for patients of the care and treatment provided. Outcomes of treatment were monitored to assess the effectiveness of the service. Outcome measure reports were prepared for each service.

Information to support staff practice and current information about patient care and treatment was available through the trust intranet, which provided an excellent source of information to support staff in their work. Patients consent was requested appropriately. Training updates for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were being rolled out across community services. Staff used best practice procedures in patients' home settings. Staff training and development was supported.

Multi-disciplinary working and joint arrangements worked well and supported joined up working between community based teams. Community health services for adults used multi-disciplinary teamwork to support the coordination of care pathways.

Detailed findings

Evidence based care and treatment

- The service used National Institute of Clinical Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. We saw evidence of references to the use of national guidelines within a number of community services.
- Staff could access guidance and pathways for certain long-term conditions on the trust intranet. We found the rapid response service used national guidance in the form of patient group directions (PGD's) in the administration of prescription medicines. We reviewed several examples of PGD's and other guidance being used in the service to inform practice.
- Staff understood their individual roles and responsibilities in the delivery of evidence based care. Staff referred to relevant codes of practice. Staff used nationally recognised assessment tools to screen patients for certain risks. For example, infection control procedures. Patient's assessments were completed using templates that followed national guidelines. For example, skin integrity, falls risks, nutrition, pain management, and activities of daily living. Records we viewed were completed in a timely way and at appropriate intervals.
- Staff we spoke with understood how NICE guidance informed local guidelines. We observed staff following appropriate assessment guidelines when delivering care to patients.
- Staff received the minutes of meetings where guidance was discussed; these included changes to practice which might affect their area of work. Audits were used in the service and informed the development of local guidance and practice. For example, as a result of the integrated care audit clinical staff were trained in level two safeguarding for adults and children.

Pain relief

- Patients with specific pain symptoms had pain assessments and care plans. A recognised assessment tool supported by national guidance was used to manage the support of patients with pain symptoms. We found that patients' pain was assessed appropriately. We found care plans indicated if a review was required.
- District nursing teams told us they regularly contacted Macmillan nurses for advice and guidance in regards to pain management.
- Our review of patient records confirmed that patients were assessed appropriately for pain symptoms.

Good

Are services effective?

- Specialist nurse teams could refer patients directly to the pain service. District nursing staff accessed pain clinics by liaising with patients GP's.

Nutrition and hydration

- A recognised assessment tool supported by national guidance was had been introduced by the service in 2015 to review the appropriateness of patients' nutrition. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese.
- Patients' nutrition and hydration assessments we viewed were completed appropriately. Care plans were in place for nutrition and hydration and reviewed regularly. Community nursing teams completed a comprehensive audit of people's food and drink needs as part of the integrated care audit in 2014. The results were RAG (red, amber, green) rated. The community teams were achieving 100% compliance in most areas of meeting patients' nutritional needs. None of the needs audited received a red rating.
- Where a need for additional support with nutrition and hydration was identified, for example with diabetic patients, community and specialist nursing staff referred patients to a dietician.
- Clinics for patients with diabetes were attended by a dietician to provide practical advice for patients about healthy food choices and to work with patients to change their eating habits.
- Information leaflets about nutrition and hydration were available for patients. For example, a leaflet, "preventing dehydration in older adults - advice for patients and carers", gave patients and carers advice on spotting the symptoms of dehydration and advice on how to avoid becoming dehydrated.
- Gateshead community teams had a steering group to direct a malnutrition task force. A survey found the trust's community malnutrition project had resulted in: older people or carers who said they had no information reduced from 29% to 14%; number of older people carers who said they had enough information on nutrition increased from 26% to 32%; and healthcare professionals recognition for symptoms such as 'a lack of food in the cupboard or fridge' increased from 59% to 71%.

Technology and telemedicine

- The trust's electronic system, HYDRA, was used by the district nursing service to manage patient referrals and plan appointments for home visits.
- Telemedicine is the use of modern telecommunications equipment, such as telephones and video, to allow health care professionals to communicate with each other and with patients in their homes, in order to provide medical care. The cardiology team had adopted the use of telemedicine to provide on-going management and support for stroke patients.
- Staff told us that the service did not have direct access to GP records systems. Information from GP's was faxed to community services for adults. Staff told us the trust was transitioning to EMIS a computerised records management system for integrated community services. EMIS is an electronic system whereby healthcare professionals can share and use vital information, so they can provide better, more efficient care. Arrangements were in place for staff to receive training in the new records management system. Staff said negotiations were in progress with GP's to enable information sharing between community nurses and GP's using EMIS.

Patient outcomes

- Outcome measure reports were prepared for each service. For example, community quality indicators outcome measures reported the number of grade two, three and four pressure ulcers occurring within each district nursing team. Staff told us the information was updated on a monthly basis to aid monitoring and to identify themes in pressure ulcer care.
- It is a national requirement that category three and four pressure ulcers are reviewed using RCA. A pressure ulcer RCA panel met monthly to identify any lapses in care and avoidable pressure damage. The pressure ulcer panel reviewed in collaboration with the clinical staff involved, actions taken, and further action that needed to be taken. The panel examined if the ulcer could have been avoided and ascertained if the incident occurred during an episode of care. RCAs carried out on category three and four pressure ulcers identified that 95% of pressure ulcers were deemed unavoidable with no lapses in care.
- District nursing teams identified areas that needed to be reviewed and audited in team meetings. For example, the west locality district nursing team reviewed systems

for effective communication to ensure continuity of care, such as referral to specialist services. We saw evidence on the team's audit plan that actions required as a result of the audit had been identified and an action plan was in place.

- Tissue Viability (TV) nurses at Carr Hill leg ulcer clinic told us the service had action plans for a number of interventions that had been developed as a result of the learning and monitoring of pressure ulcers and the learning from RCA and pressure ulcer panels. For example, the TV service had developed a pressure ulcer reduction action plan to monitor management and improve the performance of pressure ulcer care. This involved pressure ulcer incidence being analysed and monitored by the trust and TV service. Information was gathered in relation to the categories of pressure ulcers and the cause and circumstances relating to the pressure ulcer.
- The trust's "choose high quality care" quality report for 2014 stated that the district nursing service saw approximately 50,000 patients per month. The trust used data from the NHS safety thermometer to compare the trust's performance with the national prevalence. For pressure ulcers the trust's prevalence in 2013-2014 was 0.74% compared with the national prevalence of 1.14%. The report stated that the trust was "not a national outlier in pressure ulcers and action was being taken to further improve in 2014/15."
- We viewed the trust's community services performance monitoring spreadsheet. For example, the trust monitored: new referrals, patients new to the service, review home visits, contacts with the service, clinic activity, patients discharged from the service, inappropriate referrals, and missed calls. The assistant clinical business manager told us that audit information was used to improve services or patient care. An example was the audit of missed calls. The manager told us the audit had identified a theme, and this had led to an investigation. The investigation was in progress at the time of our inspection.
- An annual audit plan was in place across community health services for adults. The community teams undertook 104 audits in 2014. All community teams were involved in the trust's integrated/essence of care audit 2014-2015.
- Audits of community adults' services were undertaken to monitor the outcomes of care and treatment patients received. Staff in a focus group confirmed that all staff were engaged in regular audits. Staff confirmed that clinical leads provided feedback to teams on the results of audit activity. The results of audits were shared with staff. We saw audit results displayed on staff notice boards in community locations. For example, hand hygiene audit results were displayed on staff noticeboards as well as up to date NHS safety thermometer results.
- The rapid response team used the NHS safety thermometer and medicines safety thermometer. Safety thermometer results were discussed at team meetings and displayed on staff notice boards in team locations.

Competent staff

- District and specialist nursing staff had received annual appraisal as an aspect of their continuous professional development (CPD). Community nursing teams had achieved at least 90% of staff in each team having received an annual appraisal in the previous 12 months. In the rapid response team 100% of staff had received an annual appraisal. Across community services a high level of compliance was reported overall.
- A corporate induction was completed by staff joining the service. Staff told us new staff also received an induction at locality level. The trust provided staff with information about training events to support and enhance competencies in particular skill areas relevant to the service. For example, staff attended a pressure ulcer learning event in 2014 and an action plan was in place for all staff to receive dementia awareness training in 2015.
- Staff training and development was supported. We found the service encouraged skills development. Staff of different grades confirmed that training needs were identified as part of appraisal, and staff could request further training that was relevant to their role. Staff were supported to continue their education. For example, we spoke with staff members whom the trust had supported through further and higher education who had developed into more senior roles. We spoke with a HCA who was studying for a nursing degree with trust sponsorship. Clinical shadowing was also used to advance the knowledge and skills of staff.
- Staff told us individual supervision took place every four to six weeks, and there was regular supervision in team

meetings. However, managers and staff told us clinical supervision was an area the trust had identified as requiring improvement, as this had not been prioritised during the move to integrated working.
- Pressure ulcer care was a priority with the trust. District nurses were receiving training to provide assurance of competence in leg ulcer management. The numbers of staff that cancelled or did not attend were monitored and managers copied into the correspondence to encourage attendance and compliance with the leg ulcer policy and standards for practice.

Multi-disciplinary working and coordinated care pathways

- Work was in progress for community locations to move into shared accommodation, as part of the trust's integrated care agenda. Staff who had already moved told us they felt the joint arrangements for accommodation worked well and were an advantage in supporting joined up working between community based teams. Staff said they felt aligned with colleagues in other specialisms and part of an integrated team.
- Multi-disciplinary team working supported the coordination of care pathways for patients. Community nursing teams were aligned with GP practices. The service had close working arrangements with GP practices and with social services in supporting patients care and treatment in the community.
- A focus group of allied health professionals, including physiotherapists and occupational therapists told us the intermediate care team worked effectively with other specialisms, this included integrated care pathways and joint assessments.
- Specialist nursing staff provided support for community clinics and professional advice for district nursing colleagues to support multi-disciplinary working and the use of best practice for patients. Nursing staff told us they felt well supported by other professional staff that provided multi-disciplinary support.
- Specialist clinical leads worked effectively in multi-disciplinary teams. For example, the clinical lead for the specialist musculoskeletal clinical assessment team (MSK CATS) service maintained links with other specialists including physiotherapists, podiatry, occupational therapists and the falls team. MSK CATS is a community based service which offers patients in South Tyneside assessment, diagnosis and treatment of musculoskeletal issues such as joint and muscle pain and ligament and tendon problems
- For district nursing, multi-disciplinary team meetings could be convened to address the needs of patients with complex care needs.

Referral, transfer, discharge and transition

- The service had agreed referral pathways and procedures in place. Referrals to community services were from a variety of services including GP's, practice nurses, district nurses, patients being discharged from hospital, complex cases in nursing and residential care homes, and others, including the police. District nurses could refer patients for urgent assessment to the rapid response or intermediate care team to prevent a hospital admission. Staff told us there were clear criteria for referral of patients which meant that inappropriate referrals could be identified.
- The intermediate care team facilitated discharges, reduced long-term care and provided out of hours nursing services. Therapists in the team provided goal-orientated, time limited interventions, aimed at improving patients functioning and independence. Nurses in the team could arrange domiciliary services to prevent avoidable admissions to hospital and could ensure access to community nurses 24 hours a day. Staff from the intermediate care team told us they worked closely with the discharge nursing team at South Tyneside district hospital.
- Discharge arrangements from hospital were supported by community teams. For example, the cardiology specialist nurse attended multi-disciplinary team meetings at the acute hospital with cardiology consultants and liaised closely with community nursing teams about discharge arrangements.
- The rapid response team told us that inappropriate referrals from the acute hospital had reduced due to the hospital teams improving communication.
- Patients were discharged from the community nursing caseload if they were admitted to hospital. Community nurses liaised with the hospital ward to support patients' admission. If a patient was due to be discharged to their home, the acute hospital would refer

to the SPOC. The district nurse who was allocated the patient may visit the ward to check that the patient was comfortable to return home, and would arrange the intervention from the community team.

Access to information

- Information to support staff practice and guidance about patient care and treatment was available through the trust intranet, which also provided signposting and links to external internet sites. Staff felt the trust intranet provided a good source of information to support their work. Clear, comprehensive evidence based content was available on the website for all clinicians.
- We reviewed a sample of information on the trust intranet that staff used to support their work. The information was clear and accessible. Staff told us they received briefings, newsletters, and updates about particular themes by email on a regular basis.
- We spoke with the rapid reaction service administrator who told us they checked referral information and discharge documents. If information was missing, this was requested, and when the referral was seen to be correct it was assigned a traffic light code: red, if arranging to see the patient in two hours; amber, for the same day, and green for other referrals. Patient details were registered on the electronic system and assigned to a member of staff according to the patient's urgency and complexity of need.
- In community locations, information displayed in the staff area was up to date and relevant.
- District nursing staff told us remote working was being introduced to community nursing teams as part of the trust's integration agenda. Staff said a date for the introduction of remote working was in the process of being finalised.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence of verbal consent being obtained before care was delivered. We reviewed consent information for a selection of patients as part of our review of records. We found consent was obtained and records were completed correctly.
- Where nursing staff used photography to obtain a record of the patient's condition and symptoms, this was done with the patient's written consent.
- The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Standards (DoLS) training was being rolled out across the trust in 2015.
- Staff we spoke with demonstrated understanding of the MCA and of their responsibilities under DoLS. A mental capacity assessment was undertaken if a patient refused treatment, or if nursing staff had a concern that a patient might not have capacity to consent.

Outstanding ☆

Are services caring?

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

Summary

Patients and their relatives were truly respected and valued as individuals and were empowered as partners in their care. Feedback from patients and their families was consistently positive about the way staff treated them. Patients thought staff went the extra mile in providing care, treatment, and support.

There was a strong person-centred culture. Staff were considerate and empathetic towards patients and their relatives. Staff respected patient confidentiality in written records and other communications. The approach staff used in the home setting demonstrated compassion and consideration for the patient.

Staff demonstrated effective communication skills during the examination of patients. Staff gave patients clear explanations and checked patients' understanding. Staff answered any questions patients had. Patients felt like active partners in their care. Patients individual preferences and needs were always reflected in how care was delivered. Patients were given appropriate information leaflets.

Staff were aware of the emotional aspects of care for patients living with long term conditions. Patients emotional and social needs were highly valued by staff and embedded in their care and treatment. Staff provided specialist support for patients where this was needed. Patients' independence was promoted during visits from the service. Leaflets and verbal advice about self-care were available to patients.

Detailed findings

Compassionate care

- We observed caring, compassionate care being delivered by staff across community services. Staff were seen to be very considerate and empathetic towards patients, their relatives and other people. Staff demonstrated a good understanding of patients' emotional wellbeing. People's social and emotional needs were highly valued by staff and were embedded in people's care and treatment. There was a strong visible person-centred culture. For example, we observed a district nurse talking to a patient about their family. It was apparent from the conversation that the nurse knew the family as well as the patient. The patient told us: "They are very kind and caring. I have nothing but praise for them. I would give them 10/10."
- Throughout our inspection we found the approach staff used was consistently appropriate and demonstrated compassion and consideration for the patient. Staff interacted with patients and relatives in a respectful and considerate manner. A patient told us: "Nothing is too much for them. They have popped over to the shop for me in the cold weather, to save me going out."
- The trust had rolled out the NHS FFT survey in April 2014. District nursing services had introduced the FFT in 2015. District nursing staff told us the results from the first quarter survey had not been collated at the time of our inspection.

Understanding and involvement of patients and those close to them

- Staff demonstrated excellent communication skills during the examination of patients. Staff gave clear explanations and checked patients' understanding.
- During our observation at a podiatry clinic we saw podiatry staff explaining to a patient what they could expect to happen next and the possible outcomes of treatment. The podiatrist answered any questions the patient had.
- We observed six home visits by district nursing staff. Patients told us district nurses always involved them in decision about their care and they had been involved in their care planning.
- Community nurses told us they photographed all wounds every four weeks, and these would be shown to patients to demonstrate wound progress. We saw district nurses taking time to clarify patients' understanding of their care and treatment: carers told us they were reassured by the nurse's knowledge and advice.
- Specialist nursing staff provided an educational resource for patients and carers. For example, staff at the community cardiology nursing team provided care

to patients with disorders of the heart and blood vessels. Staff we spoke with told us they also provided patients, families and carers with education about heart disorders, as well as advice and support.

- The service's TV team provided support with skin care. TV specialist nurses provided telephone support for community teams and facilitated training days. At local shopping centres the tissue viability team provided public information days on the prevention of pressure ulcers.
- Confidentiality was maintained in discussions with patients and their relatives and in written records and other communications.
- Staff told us a patient welfare service was provided by the trust to provide support for people and to provide advice and information to people who were bereaved. However, as we did not visit the patient welfare service during our inspection, we did not see any of the information the patient welfare service provided,.
- Comprehensive advice and information leaflets on care and treatment were available across community services. Patients could access these from the trust's website.

Emotional support

- We observed staff providing emotional support to patients and to relatives. Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for patients where this was needed. Relationships between patients and staff were strong, caring and supportive. Relationships with patients and their families were highly valued by staff.
- During home visits we observed staff responding to people in a kind and compassionate manner. Feedback from all the patients and carers we spoke with was positive about the emotional support the community staff provided. Patients thought that staff went the extra mile and the care they received exceeded expectations. A patient told us: "They are lovely people. They cheer me up. You can have a good laugh with the nurse who usually visits me."
- We observed telephone calls staff made with patients. Staff consistently demonstrated good communication skills and a caring approach to patients. We saw patients being advised by staff in a caring, competent, and compassionate manner, which maintained their dignity.
- We observed care and treatment being delivered by district nurses to patients in their own homes. We saw them respecting and maintaining patients' dignity and administering care sensitively and with compassion. For example, because the patient lived on the ground floor, a district nurse asked the patient's permission to draw window curtains, to support the patient's privacy and dignity whilst receiving care and treatment.
- We observed care and treatment being delivered by podiatry and cardiology staff. We found on both occasions staff ensured patients privacy and dignity were maintained. Discussions with patients were conducted with appropriate sensitivity to their needs.
- Patients we spoke with were very positive about the care and treatment they received. A patient told us: "I know them very well. I see the same nurses every time. They're more like a friend visiting. They always have a chat and ask me how I am. If they are a bit busy they let me know that they can't stop for long but, generally they will always have a chat."
- We observed that letters and cards received from patients were displayed in the community locations we visited. We reviewed over 10 of the patient comments and found them to be consistently positive.
- The promotion of self-care was of particular relevance to the care of patients in community settings. We observed patients' independence being promoted during home visits and clinics. Information leaflets were available to patients in clinics and were distributed by community nurses. For example, during a home visit we viewed a patient's records and saw that they had a "falls prevention" leaflet attached to their records.
- We observed a podiatry clinic session for patients with foot care needs. We saw the podiatrist explaining foot self-care to a patient. The patient was invited to ask questions about self-care, and was given written information that explained what they could do in regards to caring for their feet.

Good

Are services responsive to people's needs?

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

Summary

A range of specialist teams were used to provide services in the community which met patient needs closer to home. Community services managers and staff worked with local commissioners of services, the local authority, other providers, GPs, and patients to co-ordinate and integrate care pathways. For patients who required support for mental health or social care needs, arrangements for care and treatment were facilitated with mental health or social services. There were good working relations with the South Tyneside district hospital. Patients benefitted from joined up care when admitted to hospital.

The service used a SPOC to help ensure patients got the right care at the right time, and to avoid admissions to hospital. Patients could access community health services promptly. Referral to community health services followed agreed pathways of care. For most services, service specifications were in place which included expected outcomes for patients.

Staff were aware of complaints that patients had raised about their service area, and actions the service had taken to resolve the complaint. Actions following the investigation of a complaint were identified and discussed with patients: the completion of actions were monitored. Staff could describe how services had changed as a result of action taken.

The intermediate care team service provided care to prevent hospital admission, facilitate and reduce long-term care and provide out of hours nursing services 24 hours a day.

Staff were trained in equality and diversity. The trust had designated dementia champions in community teams. Training for all clinical staff in caring for patients living with dementia was being rolled out across the trust.

Detailed findings

Planning and delivering services which meet people's needs

- Community services were in transition to a model of integrated community teams across health and social care. The aim of the service model was to improve patient outcomes and experience through bringing existing community services from health and social care into a more combined way of working, with the aim of reducing the number of different professionals that patients needed to interact with, reducing duplication of work, and increasing the focus on personalised care and self-care.
- The assistant clinical business manager told us the service's integrated community teams model was being rolled out in stages. The integration agenda was different in Sunderland, South Tyneside and Gateshead. This was to reflect the differing priorities in each area. Locality managers we spoke with were aware of the differing priorities in their local area. For example, South Tyneside had more patients with complex conditions.
- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- The Trust's community services were part of the national Pioneer programme which is aimed at transforming how services and organisations work together to empower patients to take greater control of their own health and care requirements. This programme was developing and required further embedding to ensure it involved all teams within community adult services.
- The trust told us the service's integrated community teams' model was being rolled out in stages to provide a tailored service to each of the three Sunderland Boroughs and the City. This was to ensure a responsive, local service tailored to the local needs of residents, service users and partner organisations was in place.
- We found that service specifications were in place for most services which included the aims and objectives of the service, as well as the expected outcomes for patients. Staff we spoke with told us they had developed good working relationships with commissioners, other providers and stakeholders to ensure multi-disciplinary working and continuity of patient care. For example, staff told us about the trust's acute respiratory assessment service (ARAS). ARAS provided a specialist

service for the assessment, management and treatment of patients with respiratory conditions. The team worked with community matrons and district nurses to assess and treat patients, aiming to prevent hospital admissions. ARAS facilitated assisted discharge of patients from hospital and provided on-going community support in the form of home visits and monitoring. Staff told us ARAS were equipped with portable back up oxygen cylinders that could be recharged in their cars in the event of a power cut in a patient's home.

Equality and diversity

- Equality and diversity training was mandatory for the service. However, we noted from the trust's training record that a number of community nursing staff were recorded as not having completed equality and diversity training. However, we viewed local records and this recorded that some staff shown as not having completed on the trust's register had completed the training. A community nursing manager told us there were sometimes delays in training information displaying on the trust register due to staff not updating their training records promptly.
- Staff we spoke with told us that people's cultural and religious needs were assessed as an aspect of patients' initial assessments. Patients' records included specific information on their cultural or religious dietary preferences, ensuring that food and drink met their religious or cultural needs.
- Upon request the trust's customer services department could provide information documents in other languages, large print, Braille and audio format. Staff told us that there the service did not have high demand for information in other languages and it would not be cost effective for the service to produce these in large amounts and make them available at all clinics because patients could request information and receive it quickly from the customer services department.

Meeting the needs of people in vulnerable circumstances

- Dementia awareness training was being rolled out to all staff working in community based teams. District nursing teams had completed dementia awareness training delivered in partnership with the Alzheimer's Society. Managers told us that teams had started to recruit dementia leads who would lead on dementia awareness.
- The butterfly scheme provides a system for patients living with dementia which enables staff to identify them quickly. We saw that on some patient records the service used the butterfly symbol on patient records. Staff told us this acted as a visual prompt to aid staff in identifying patients with a diagnosis of dementia.
- The learning disability service provided specialist multi-disciplinary assessment and intervention to individuals aged 18 and over with learning disabilities and complex health care needs. For example, physiotherapists in the community MSK CATS service provided services for patients living with a learning disability and long-term conditions such as cerebral palsy. The team also provided advice and support to patients, carers, and other professionals.
- Physiotherapy departments were accessible to wheelchair users and bariatric patients.
- The community matrons' team told us they mainly worked with patients with complex needs, and their carers, to develop personalised care plans, as well as coordinating care with other health and social care professionals. The role of the community matrons was to manage patients' conditions in the community and prevent unnecessary admission or attendance at hospital. However, if patients required hospital admission, staff told us they worked with the hospital to support patients with complex needs when they were discharged. Staff we spoke with told us that patients benefitted from joined up care as a result of the good relationships between community services and the acute hospital.

Access to the right care at the right time

- The service used a SPOC to triage and signpost patients. This meant patients could be sure they received the right care services in a timely way. Services responded quickly and waiting times were low in the service areas we visited.
- We viewed the district nurse quality indicators for Gateshead. We found that between April 2014 and March 2015 100% of patients who were triaged by the traffic light triage system as red, were seen within two hours of referral; 99% of amber triaged patients were

seen within 24 hours; and 99% of green triaged patients were seen within 48 hours. This meant patients assessments were consistently within the expectations of patients and commissioners.

- At the SPOC in Gateshead we observed a nurse undertaking call triage for incoming calls from hospital and GP practices. The triage nurse linked with district nurses within clusters of GP practices to arrange visits and care for patients. Triage decisions were informed by the schedule of nursing visits already planned, and the rapid response service was used when the number of unplanned calls exceeded capacity, typically after six unplanned calls were received, or calls were deferred to the next day. Staff phoned the patient if a visit was deferred.
- Patients with diabetes or at risk of diabetes had access by referral from a health care professional to specialist community diabetes services, this included patients with renal disease, foot care, and retinal disease. The service had a 24 hour on-call insulin pump service and metabolic clinics for patients with complex needs and unstable diabetes. The service offered a diabetes service for young people between the ages of 16 to 25 years. The trust informed us that a consultant kept in touch with hard to reach young people by email, to provide support and advice if a young person was unwilling to attend the diabetes clinic. The diabetes team had links with the paediatric diabetes team for transition and handover of patients at the age of 16 years.
- Patients could access community services promptly. For example, within the MSK CATS, 100% of patients were given an appointment within the required timescale, with between 80% to 93% being seen within 18 days of referral to the service. Referral to the service was via GP or physiotherapy referral.
- We observed patients attending a podiatry clinic. The podiatry service did not accept self-referral: patients using the podiatry service were referred by a health care professional. We saw patients receiving a full physical examination of their foot. During the observation we saw podiatry staff explaining treatments to patients in accessible language, as well as agreeing future care and treatment plans with patients.
- Community health services had submitted a business plan to receive funding from the care commissioning group (CCG) to create a specialist district nursing team for residential and nursing homes, with the aim of arranging care and support that avoided patients being unnecessarily admitted to hospital from care homes. The work involved assessing, reviewing, and monitoring patients in care homes taking nutritional supplements to ensure their dietary needs were met.
- We observed care being delivered by the 24/7 rapid response team. We saw a nurse providing intensive home support. The nurse demonstrated the use of extended skills. The team responded quickly, within four hours, to calls to the service. This meant new patients received quick assessment and planning for new and existing chronic illness such as chest problems, and arthritic pain affecting their mobility.
- A range of specialist teams provided care and treatment in the community. For example, diabetes, respiratory, tissue viability, continence, falls, and stroke teams. Community district nursing teams attended the needs of patients who were assessed as needing care in their own homes. For patients who were able to travel to local centres, the service offered a range of community clinics. For example, podiatry and physiotherapy. The cardiology nursing team provided care to patients with disorders of the heart and blood vessels. The trust informed us that the community SALT team worked closely with the SALT team at the hospital.
- Community matrons used the same documentation as the district nurses. This meant that patients had a contemporaneous record of their care, and community staff had easy access to the patient's record. Community matrons told us they worked well with the district nursing service and felt their roles were complimentary.
- Managers told us that if necessary staff would work across areas to meet targets for responsiveness. Patients we spoke with confirmed they had experienced short waiting times to access services.
- We observed nursing staff at the rapid response team in Sunderland taking calls to the service. Staff told us they could provide support to the hospital teams if demand for services was low in their service. The rapid response team provided out of hours support to community nursing patients between the hours of 5pm to 8.30am. The service provided intermediate care to prevent hospital admission, early discharge support or acted as a supplement to other services. The service aimed to respond to calls within two hours.

Learning from complaints and concerns

Good

Are services responsive to people's needs?

- The trust had complaints handling policies and procedures in place. All complaints to the service were recorded. Information on the trust's complaints policy and procedures was available on the trust's internet website.
- Community nursing services had 13 complaints in the previous 12 months. Four of the complaints had been upheld by the service and an apology had been provided to the patients involved. Complaints were monitored by the assistant clinical business manager to identify any themes. Actions taken to address complaints were recorded on the complaints log.
- Information for patients about services included information about how to make comments and compliments or raise concerns or complaints and information about the patient advice and liaison service (PALS). Most patients we spoke with were aware of the complaints procedure.
- Staff we spoke with were aware of the trust's complaints policy and of their responsibilities within the complaints process. For formal complaints, patients were directed to the trust's customer services department and informal complaints were logged on an informal complaints record. Staff were aware of complaints patients had raised about their service area and of what was done to resolve the complaint. Action to be undertaken following the investigation of a complaint was identified and discussed with the patient. The completion of actions was monitored. Line managers fed back learning from complaint investigation at team meetings. Staff could describe how services had changed as a result of action taken.

Good

Are services well-led?

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

Summary

The service regularly undertook a range of audits to improve performance and support safety. An annual plan for clinical audit of the service was in place and progress. Clinical governance meetings were held monthly, topics included risks, audits, and actions taken. Regular locality and team meetings were held which were sometimes attended by specialist nurses and allied health professionals.

Community services had carried out patient satisfaction surveys, with positive results. The service had an award winning innovative electronic system, HYDRA.

Managers and staff told us they felt the integrated care model provided a clear vision for community services. A strategy of improvement and changes to service delivery was being implemented.

Staff felt there was clear leadership at executive level and the executive team were approachable. Managers and team leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was effective and staff said their direct line managers were supportive.

The service had a risk register that was reviewed regularly: however it didn't reflect staff long-term sickness absence as a risk or have a specific action plan recorded. Staff were able to demonstrate action the service had taken to mitigate the risks caused by staff long-term sickness absence.

Staff were supportive of each other within and across teams.

Detailed findings

Service vision and strategy

- The trust's vision was to provide "the best care for our patients, in the best place, at the right time." To deliver the vision the trust had a quality strategy with the strategic objective of delivering high quality and safe services to patients. The strategic aims were: safe care; effective treatment and quality services. The trust's value statement was displayed on notice boards for staff, in the community locations we visited, as well as on the trust's intranet and internet.
- Managers in community services had developed a local vision and strategy for their service and linked this to the trust's vision and strategy. The local vision and strategy was displayed in community nursing offices. Most staff we spoke with told us the trust's vision and strategy was publicised on the trust's intranet, and they incorporated the trust's values into their practice.
- The trust's strategic plan 2014-2019, "choose change – driving transformation forward", involved community services working with commissioners to agree the scope of their moving to a model based on GP and local authority geographical areas. The approach would differ in each area to reflect local need, but the aim would be the same. Community services would have multi-disciplinary staff in local teams to smooth the patient pathway and ensure continuity of care. Some of the work had been completed in the last year.
- Managers and staff told us they felt there was a clear vision for community services and a strategy of improvement and change to services delivery. The vision and strategy for community services was centred on integrated, safe and effective care for patients, closer to home. Some of the services we spoke with told us they had been engaged and included in developing the vision and strategy for their team.

Governance, risk management and quality measurement

- The service had governance and risk processes in place. The trust had an up to date risk management policy in place. Community services maintained a risk register. The register was reviewed regularly and most staff were aware of the risks in their service area and the action taken to mitigate risks. However, other staff we spoke with were unaware of the risk register and felt it was not readily accessible.

Good

Are services well-led?

- We reviewed the minutes of monthly district nursing team meetings. Ongoing locally managed risks were discussed and trust wide risks were also linked to clinical governance meetings. For district nursing services, key risks included long-term staff absence.
- The service regularly undertook a range of audits to improve performance and support safety. We noted that district nursing teams had undertaken a comprehensive integrated/essence of care audit in the previous 12 months. We noted the west locality audit had identified actions and changes required as a result of the audit. However, not all recommendations had been actioned. Staff told us some of the recommendations had been implemented, and the audit record needed to be updated to reflect actions the service had taken and actions that were still outstanding.
- Minutes of clinical governance meetings evidenced that an annual plan for clinical audit of the service was in place and progress was reported monthly. Locality and specialist team meetings also evidenced that audit plans were in place and were reviewed by the service at monthly meetings. Updates were provided for audits in progress. For example, the TV service carried out a failed visit audit in June 2014 to capture the amount of failed visits scheduled by the team. As a result of the audit recommendations were implemented. These included the service providing telephone reminders to patients prior to their clinic appointment and contacting the community nurse service for community joint visits.
- The district nursing service used the NHS safety thermometer to monitor: pressure ulcer care; falls; catheter care; and venosthromboembelism (VTE). Managers told us the safety thermometer information was used to identify trends and identify improvements in patient care over time. Every team received their own individual results which were used to make changes in care delivery.
- The trust's information management team monitored community services performance against a number of criteria. For example, patient contacts; failed visits; and inappropriate referrals. The information management team used data from the trust's electronic systems to identify any significant differences in community teams' performances on a month by month basis.
- Community services had been involved in a number of national audits. For example, the podiatry service had been involved in the national diabetes foot care audit (NDFA). This enabled the service to measure their performance against NICE clinical guidelines. The specialist respiratory service had been involved in the national chronic obstructive pulmonary disease (COPD) audit in 2015. COPD, is an umbrella term for a group of diseases, which include asthma, chronic bronchitis and emphysema. The trust produced a quality and clinical audit report annually. We viewed the 2014 report, this highlighted how the report prioritised its audit programmes on the basis of national priority, trust priority, national good practice, and clinical interest.
- The trust had a number of ways of engaging with staff. For example, the joint consultative committee and monthly health and safety committee. The trust also held a monthly management forum and monthly senior clinical forum where the chief executive discussed key topical issues, with senior and middle managers and senior clinicians.
- The trust had introduced a staff recognition strategy in April 2014. This introduced employee and team of the month awards, where staff had the opportunity to nominate colleagues and teams who they felt had gone the extra mile.
- Managers and staff told us regular locality and team meetings were held which were also attended by specialist nurses. Our review of documents showed that these meetings were recorded and included case discussions. Actions taken were documented and reviewed in subsequent meetings.

Leadership of this service

- The chief executive was well established in their role and known to staff in community services. Staff felt there was clear leadership at executive level. Staff told us the chief executive was approachable. Managers told us they had attended staff briefings with the chief executive.
- The service had recently undergone a significant reorganisation of services. Managers and team leaders demonstrated a clear understanding of their role and position in the trust. However, we found that community teams were not fully integrated at divisional level. For example, district nursing services were in a different division to some therapeutic services. Staff told us they were unsure of how divisions communicated with each other.

Good

Are services well-led?

- Local team leadership was effective and staff said their direct line managers were supportive, although we also encountered some exceptions. The senior management team for community services provided leadership although it was not always visible to staff.
- Staff in specialist nursing teams felt their line managers were supportive and accessible. Although they did not often encounter senior management, they felt they knew how to access them if required.
- Health care assistants we spoke with told us they felt comfortable in their role and well supported in their development.

Culture within this service

- Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. Staff told us they were able to put forward ideas and discuss them as a team.
- Most staff were receptive to the integrated service agenda and felt positive about the changes the trust were making.
- Staff said the trust was good to work for, with an open and patient focused culture. Staff said they had been consulted and felt involved in the decision making process.
- Some staff told us that during winter they did not feel they had the time to spend with patients to provide the emotional support they required as pressures on the service had led to them being task focused.
- Staff generally reported a positive culture in community services, although we encountered exceptions in some locations, where staff felt uncertain about the pace of roll out of the trust's integrated care agenda.

Public engagement

- Community adult health services were to commence engagement with the public through the NHS Friends and Family Test commencing January 2015.
- The 'open and honest care: driving improvement programme' aims to support organisations to become more transparent and consistent in publishing safety, experience and improvement data, with the overall aim of improving care, practice and culture. We viewed the trust's April 2015 results. This found that 92.3% of patients did not experience any harm whilst community services were providing care and treatment that month. The results of the survey were available on the trust's website.

Staff engagement

- Staff notice boards in some community locations displayed thank you cards demonstrating that patients and relatives had taken the time to write and thank staff.
- The staff monthly bulletin provided staff across the trust with the opportunity to share news and information with each other about events.
- During the integrated care reorganisation service managers were briefed and felt senior managers were receptive to their comments. We were informed that support was available for staff during this process through weekly meetings and training sessions.
- Other regular staff communication and engagement forums included a team brief and "cheer up friday", where the chief executive shared some of the commendations and thanks the trust had recieved.

Innovation, improvement and sustainability

- Several examples of new and emerging innovative practice were observed during our inspection.
- The trust's electronic referral and caseload scheduling for community nursing system, HYDRA, won the 'embracing technology' category at the lean healthcare awards in 2014. The awards recognised excellent service improvements and enhanced efficiencies carried out by healthcare organisations. HYDRA was also a runner-up in the national patient experience (PEN) awards.
- Community services had submitted plans to the clinical commissioning group for a care home initiative. The aims of this were to reduce hospital admissions from care homes, reduce dementia diagnosis in care homes, enhance liaison between multi-disciplinary teams, and standardise challenging behaviour pathways.
- The trust had introduced the SPOC initiative to address potential delays arising in sourcing appropriate care for adults identified at risk of hospital re-admission or unnecessary admission into long term residential and nursing care in the absence of other suitable alternatives.
- South Tyneside were the first trust in the NHS to implement PERFORM, a people focused performance monitoring system. The initiative had enabled the trust to release £7 million in financial benefits.

Good

Are services well-led?

- The Trust's community services were part of the national Pioneer programme which is aimed at transforming how services and organisations work together to empower patients to take greater control of their own health and care requirements.
- Sunderland locality was awarded national "Vanguard" status by NHS England. Vanguard sites will take a lead on the development of new care models which will act as blue prints for the health and care system in England.