Care Quality Commission

Oxford Health NHS Foundation Trust

RNU

Community health services for adults

Quality Report

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Date of inspection visit: 28 September 2015 - 2 October 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)
RNU10	Oxford Health NHS Foundation Trust- HQ		

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

Summary of findings

Ratings

Overall rating for the service	Good	🟢
Are services safe?	**Requires improvement**	🟠
Are services effective?	**Good**	🟢
Are services caring?	**Good**	🟢
Are services responsive?	**Good**	🟢
Are services well-led?	**Good**	🟢

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Overall summary

Overall rating for this core service Good O

Overall, we rated this core service as ''good''. We found that community services for adults at Oxford Health NHS Foundation Trust were, ''good'' for effective, caring, responsive and well-led services but ''required improvement'' to be safe.

Oxford Health NHS Foundation Trust is the main provider of community health services for adults in Oxfordshire. Services are provided to patients in their homes and at a number of clinics held at community hospitals, health and wellbeing centres and GP surgeries. Care and treatment are provided under the regulated activates: treatment of disease disorder or injury and diagnostic and screening procedures.

Our key findings were:

- There were periods of understaffing across a number of community services. This impacted on patients receiving timely access to safe care and treatment.

- Pressure ulcers were the most frequently reported serious incident. Investigations into these incidents highlighted understaffing as one of the causes. A plan was in progress to reduce avoidable pressure ulcers.

- Patient records did not all contain risk assessments, or these had not been reviewed in line with trust policy, to ensure clinical risks were appropriately managed.

- There were systems and processes in place to keep patients safe, such as infection control, medicines management and servicing of equipment provided to patients. Learning from risks, incidents, near misses was shared with staff.

- Safeguarding protocols were in place and staff were familiar with these.

- Community services for adults used guidance from the National Institute for Health and Care Excellence (NICE). Services monitored and reported on patient outcomes to ensure they were providing an effective service to patients.

- There was well established multidisciplinary team working across almost all the community services we visited. There was an effective system in place for referral, transfer and discharge of patients.

- Staff had completed statutory and mandatory training and described good access to professional development opportunities.

- Not all patients had a malnutrition risk assessment completed at their first visit, in accordance with the trust nutrition and hydration policy.

- Patients received compassionate care that respected their privacy and dignity. Patients told us they felt involved in decision making about their care. We found staff were caring and understanding. Without exception, patients we spoke with praised staff for their empathy, kindness and caring approach.

- Services were planned and delivered to meet the needs of the local population. Services were supportive, adapted to meet the needs of people in vulnerable circumstances and made arrangements to meet the diverse needs of local people, such as through access to translation services.

- Waiting times for most outpatient services were outside the trust target of first appointment within 12 weeks of referral. Actions plans were in place to respond to these issues. Delayed transfers of care were an ongoing concern for the trust. Work was taking place with multiple providers to continue to address this.

- Elements of the trust's vision and strategic forward plan had been implemented in community services, through the implementation of integrated locality teams. Staff were adjusting to this new model of working, but could see the long-term benefits for patients.

- There were effective arrangements in place, to monitor quality and safety. Staff felt supported by their immediate managers. The culture within community services was caring and supportive. However, staff felt senior management did not always listen to or respond to concerns or suggestions for improvement to services.

Summary of findings

Background to the service

Information about the service

Oxford Health NHS Foundation Trust is the main provider of community health services for adults in Oxfordshire. It provides services to a population of approximately 531,000 people living in Oxfordshire.

Community services were provided through a network of six integrated locality teams based around Oxfordshire. The integrated locality teams had been operational for nine months, with staff in a period of transition to this new model of working. These teams consisted of district nurses, physiotherapists, occupational therapists, end of life care matrons, social workers, older people's mental health nurses and voluntary services. The integrated locality teams were supported by a number of specialist county wide services, such as nutrition and dietetics, respiratory, heart failure and specialist therapy services.

Community services supported people to manage their condition at home and to avoid unnecessary admission to hospital wherever possible. Community services care for people with long-term and often complex conditions. Following discharge from hospital, people were supported by a number of services in their own home, to help them become or maintain as much independence as possible.

Services were provided at community hospitals, in people's own homes, at health and wellbeing centres and GP surgeries. Community services worked closely with the local acute trust, commissioners, adult social care services and GP's.

Our inspection team

Our inspection team was led by:

Chair: Professor Jonathan Warren, Director of Nursing, East London Foundation Trust

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

Team Leader: Lisa Cook, Inspection Manager, Care Quality Commission

The team of 36 inspecting the community services included CQC inspection managers and inspectors. They were supported by specialist advisors, including health visitors, a school nurse, a physiotherapist, an occupational therapist, district nurses, registered nurses, a paediatrician, a pharmacist, safeguarding leads, speech and language therapists, a consultant specialising in care of the elderly, an advanced nurse practitioner - urgent care, a urgent care doctor, a palliative care consultant and palliative care nurses. Two experts by experience who had used the service were also part of the team. The team was supported by an inspection planner and an analyst.

The team that inspected community health services for adults included CQC inspectors, two experts by experience (people who use services) and a variety of specialists including a community matron, occupational therapist, physiotherapist, speech and language therapist and a district nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of NHS trusts.

Summary of findings

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 Oxford Health NHS Foundation Trust, we reviewed a range of information we held about the trust and asked other organisations to share what they knew. We carried out an announced visit on 29 and 30 September and 1, 2 and 3 of October 2015

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, 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.

For this core service

• We spoke with approximately 100 staff including nurses, therapists, support workers, operations managers, integrated locality team leads and the service director and clinical director for the directorate.

• We visited seven district nursing teams across the county of Oxfordshire.

• We also visited five community therapy teams based around the county.

• We visited a number of specialist services held at various locations in Oxford, including the heart failure community nursing team, home oxygen assessment team, pulmonary rehabilitation service and respiratory service. Also, the phlebotomy service, nutrition and dietetic service and tuberculosis service.

• We spoke with staff from the care home support service based at the west integrated locality team hub office in Witney. At this location, we also spoke with staff from the chronic fatigue and reablement service. At Witney Community Hospital we visited the speech and language therapy service.

• At Abingdon Community hospital we spoke with staff from the continuing healthcare team, hospital at home service, and tissue viability service.

• In addition county wide visits also took place to two falls prevention clinics, two integrated locality teams, two musculoskeletal physiotherapy outpatient clinics, two physical disability physiotherapy services and a reablement team.

• We spoke with 47 people who use services and three carers and family members.

• We observed 15 interactions of care by accompanying staff on home visits and observed care at outpatient clinics.

• We reviewed 16 care or treatment records of people who use services.

What people who use the provider say

We spoke with 50 patients and carers. We spoke with patients and carers at clinics, at a rehabilitation class, during home visits and on the telephone. Without exception patients and carers praised the quality of care and treatment they received from all staff working in community services for adults.

They spoke highly of the way staff involved them in the decisions about their care and treatment. All patients felt fully informed about their proposed plan of care and felt they could ask questions if they were uncertain or wished for additional information.

Patients told us staff were caring, understanding and sympathetic to their needs, always trying to resolve issues and concerns where they could. Staff were particularly supportive of patients with complex or long-standing conditions.

Summary of findings

These findings were supported by the Friends and Family data, which showed the majority of patients, would be extremely likely or likely to recommend the service to a family member or friend.

Good practice

- The home oxygen service had developed a home oxygen risk assessment tool, as no national evidenced based tool was available. The team was working with the research department at the trust to develop an evidence base for this. Staff from the team told us the tool was being used by other home oxygen services nationally in the absence of a national tool. The tool enabled staff to quantify the level of risk, work with patients and their families to mitigate the risk or to provide evidence that the risk was too great to consider oxygen therapy in a patients' home.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust MUST ensure:

- There are sufficient numbers of suitably qualified staff in all community teams to ensure safe caseload levels and timely access to care and treatment.

The trust SHOULD ensure:

- All patients have appropriate risk assessments completed at their first visit and that risk assessments and care plans are reviewed and updated at regular intervals, in line with guidance.

- All clinic rooms are fit for purpose.

- All equipment is tested and serviced at regular intervals.

- Specialist services are involved with patients' care at an appropriate stage.

- All staff complete dementia awareness training.

- Community staff are engaged in developing policies and procedures and are involved in service planning.Staff are fully consulted about changes that affect them.

Oxford Health NHS Foundation Trust
Community health services for adults
Detailed findings from this inspection

Requires improvement ●

Are services safe?

By safe, we mean that people are protected from abuse

We rated safe as ''requires improvement''.

Staffing levels in community services for adults did not meet the demand for services. Capacity was frequently exceeded for district nursing teams, meaning staff worked increased hours to ensure patients received safe care. Staff felt overworked, which impacted on staff wellbeing and retention of staff. Capacity issues were identified as a concern in root cause analysis of pressure ulcer incidents, particularly around the completion and review of risk assessments and care plans. Action had been taken to minimise the risk to patients, by sharing workloads across teams, but staffing levels did not reach the capacity needed.

Vacancy rates were high for the reablement service (19%). This impacted on patients accessing the service and delayed discharge of patients from hospital. Demand for specialist therapy services, such as musculoskeletal physiotherapy, exceeded current staffing, which meant some patients were not seen within the trust waiting time target. The trust were taking action to address these concerns, although the changes had not yet been implemented.

Process and procedures were followed to report incidents and monitor risks. Quality dashboards were used to monitor safety information such as healthcare associated infections, avoidable pressure ulcers acquired whilst in the trust's care. Learning from risks, incidents, near misses was shared with staff locally, but not shared across teams. Staff were aware of their responsibilities under the duty of candour.

Infection control practices were followed. The environment and equipment were in general well maintained. However, we did find a few items of equipment that had not been safety tested. Equipment was available for patients in their own homes and there were arrangements in place with the supplier for this to be serviced and repaired.

Medicines management was effective for patients accessing community health services for adults. Services undertook documentation audits. Some records we reviewed showed risk assessments had not been completed or reviewed. This was also reported in the district nursing notes documentation audit, particularly

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assessment of the risk of pressure ulcer and malnutrition. Staff took the time to ensure all records were kept up-to-date as patients had paper based records in their home and a centralised electronic record.

Staff were aware of the importance of managing risks to patients and we saw good examples of cross team working to support patients' needs. There were processes in place to identify high risk patients and ensure they were supported appropriately in a timely manner.

Staff across all services described anticipated risks and how these were dealt with. Safeguarding procedures were followed to protect vulnerable adults from abusive situations and staff had received safeguarding training. Staff were aware of the procedure for managing safety incidents including adverse weather and central alerting system (CAS) alerts. Most staff were up-to-date with mandatory and statutory training.

Safety performance

- The trust monitored its safety performance through use of the NHS safety thermometer and directorate quality dashboard. This NHS safety thermometer provides a monthly snapshot audit of the prevalence of avoidable harms that include pressure ulcers, falls, venous thromboembolism (VTE) and catheter related urinary tract infections. The percentage of patients receiving harm free care is also reported.
- During June 2014 to June 2015 the number of new pressure ulcers ranged from 18 to 36 per month, there were peaks in January and April 2015. The average monthly incidence was 26. The trust acknowledged in its quality report 2014/15 that there had been no reduction in the number of avoidable pressure ulcers compared to the previous year. An action plan was in place to address this.
- Falls with harm data fluctuated, with peaks November 2014 and June 2015, with 34 falls and 24 falls respectively, against a monthly average of 17. Incidence of catheter related urinary tract infections was low, with a monthly average of three. Compliance with venous thromboembolism (VTE) risk assessment was below the trust target of 100% for the same period. The average for the directorate was 86%, however, there had been no VTE events in that time.
- Across the directorate, the average percentage of patients receiving harm free care was 88% for October 2014 to July 2015.

- Data provided by the trust for April 2014 to April 2015, showed there were 18 serious incidents, across community health services for adults. Of these incidents grade three and four pressure ulcers accounted for the highest number of incidents (total of 13 incidents). There was also one medication error, one failure to act appropriately on tests results, and one incident in relation to a patient fall. For the last two incidents, there was a delayed diagnosis. The delayed diagnosis had contributed to a patient death. This incident had been fully investigated and a complaint upheld. In the same period, the trust reported 2750 incidents in community services for adults, the majority of which were either low harm or no harm. There were no never events during this time.
- Safety performance data was discussed at board and directorate level and by the leads for the integrated locality teams, with a monthly quality report produced. This included action points in response to areas of concerns.
- Safety dashboards captured data from all services within the older people's directorate, the number of incidents and degree of harm was reported specifically for district nursing service. A pilot project was being introduced in the south east and south west district nursing teams to produce location dashboards to enable teams to monitor their performance.

Incident reporting, learning and improvement

- The trust had systems in place to report and record safety incidents, near misses and allegations of abuse.
- Staff knew how to report an incident on the trust's electronic recording system. Staff told us there was no trust wide training on the reporting system, this was provided at local level. Not all staff would report an incident directly onto the reporting system themselves. Some staff told us they would report it to their manager who would log the incident. This meant there was a risk that not all incidences were reported, affecting the accuracy of the data. Managers told us that they were required to investigate incidents and produce a report within a set timeframe. Areas for improvement were then discussed with their team.
- Some teams told us they had reported very few or no incidents in the last year. A review had been completed by the trust quality and governance team on teams

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which appeared to not report incidents. Two teams, the care home support service and the chronic fatigue service were to be given additional support to ensure appropriate reporting of incidents.

- Incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place and action plans were developed to reduce the risk of similar incidents reoccurring. For example, in response to a high number of incidents related to grade three and four pressure ulcers a number of work streams had been completed. There were now specific competencies and training on pressure damage prevention and management, developed by the pressure ulcer action group. The directorate target was 90% completion. As of August 2015, uptake was around 40%, with a higher uptake amongst district nurses of 61%, this staff group reported and managed the highest percentage of patients with pressure ulcers.

- Nurses from the tissue viability service told us that colleagues did not ask for their input early enough in complex cases as per recommendations in the trusts wound healing pathway (2012). Nor was their input sought regularly with regards to the trusts action plan to reduce incidents of pressure ulcers or review of serious incidents. We did see evidence in notes of staff liaising with the tissue viability service and patients told us they had been seen by a specialist nurse. The tissue viability service were also working with patient groups to help increase awareness of early signs of pressure damage.

- The trust had introduced new care plans, which required staff to review wounds every six weeks, photograph, map and assess healing. We saw variable completion of these care plans.

- Staff were required to report as an incident any pressure ulcer or tissue damage of grade two and above, previously only grade three and four were reported. Grade three and four pressure ulcers were investigated by senior staff. Common themes were lack of in-depth risk assessments and care plans and regular review of these. However, they also highlighted the real pressures on staff, due to service demands and the impact this was having on staff wellbeing and ability to provide a safe service. The trust was hoping to secure extra funding from the clinical commissioning group (CCG) to increase the number of district nurses. Delay in providing specialist equipment, such as air-filled cushions, was also an issue.

- Partnership working took place with other providers to try and establish a set care pathway and to share learning from incidents as patients were often cared for by multiple providers.

- Sharing of learning from incidents was not consistent across all services and did not always reach staff at a local level. Staff did not feel learning was shared across teams in the same area nor across different specialities where appropriate. . We did see evidence of learning from incidents in team minutes and some staff were aware of the trust reporting and learning from incidents sheet that had recently been introduced.

- The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have, occurred.

- Staff of all grades had an awareness of Duty of Candour and their role in the process. Not all staff were aware of the trusts 'Being open policy (for incidents, complaints and claims)'. There was a training video for staff to watch on Duty of Candour. We saw evidence in team minutes that staff were reminded of the importance of completing this training.

Safeguarding

- Safeguarding adults and children at risk training was part of the trust mandatory training for staff. Staff we spoke to verbally confirmed they had completed this training, but there were no specific figures available on compliance with this training for each community team. At directorate level, the target for attendance for safeguarding adults training (level 1) and safeguarding children (level 2) was 90%, between October 2014 and September 2015 the mean compliance was 89%.

- The majority of staff we spoke to were aware of the trust safeguarding lead. A number of nursing clinical development leads commented that the lead was very supportive and approachable. They felt they could contact them with any safeguarding concerns.

- Staff could describe the different types of abuse and how they would raise a safeguarding alert. Junior staff said they would always discuss the case with their manager.

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- Minutes from the hospital at home team meeting, reminded staff when they raise a safeguarding they should also complete an incident form. The trust update on incidents reminded staff of the importance of raising a safeguarding concern.
- Staff told us that they did not always receive feedback from social services, when they had raised a safeguarding concern. This impacted on their learning and the holistic care of the patient. One member of staff told us they could access social services information through a secure link to their website, but they did not feel this was widely known about by staff.

Medicines

- Staff at the hospital at home service did not record the room temperature, where intravenous (IV) fluids were kept. Staff were aware the room could get warm and had identified this on their risk register, but no action had been taken to ensure medication was stored within the correct temperature range. Medicines were stored securely and the IV fluids used in patient homes were tamper evident.
- Patients needing treatment for tuberculosis were risk assessed, using the direct observed treatment (DOT) risk assessment, to establish likely compliance with their medication. The outcome determined if patients needed to attend the hospital to be observed taking their treatment, as full compliance was needed to ensure successful treatment. Patients who were non-English speaking were provided with a pictorial record chart, showing the tablets and how many to take. A list of serious side effects was attached to this chart, in the patient's own language so they were aware to contact the service urgently.
- The district nurses did not carry any medicines except adrenaline (medicine that is used for anaphylactic shock treatment) which they obtained either from pharmacy or GP surgeries
- There were appropriate arrangements in place for the management of controlled drugs and medicines in patients' homes. This included individual stock checks and records of controlled drugs.
- The medicines management E-learning had been updated and was to be made available to staff. District nurses told us there was a lack of trust wide training on the use of syringe drivers. This was delivered at local level. There was also a video which staff could watch.

- Staff at a focus group told us there was ad hoc sharing of learning from medication incidents.
- District nursing assistant practitioners were restricted to which patients they could administer insulin injections to as part of their scope of practice. There was a current standard operating procedure in place for the administration of insulin and for vitamin B12 injections. There was a specific care plan for patients on insulin, two versions of this were found on the trust intranet, one dated 9/07/2013, and the other 6/11/2014. We were advised after the inspection that the older version had been removed, as relevant staff had completed training on the new care plan.
- Nurses from the home oxygen service completed a risk assessment for patients needing oxygen at home. This was in line with British Thoracic Society guidelines for home oxygen use in adults (2015). The service worked with the fire service where the risk assessment showed particular concerns. The outcomes from the risk assessment were used to see if the risks could be mitigated or the risk was too high for home oxygen to be supplied.

Environment and equipment

- In general, the clinics we visited were held in rooms which were suitable for patient assessment. However, the falls clinic at Banbury was held in a narrow room, which made an accurate assessment difficult. We observed a patient being asked to stretch out their arms; they were unable to do this fully due to the size of the room, as it was too narrow. A couch, provided by the trust, was fitted in this room. The gas strut used to raise and lower the head section was broken meaning this section could not be adjusted. Staff told us this had been broken for a year, but it was now scheduled for repair.
- Staff told us there was ''good-will'' regarding use of rooms belonging to other providers. There was not always a specific service level agreement. Staff were therefore unclear who was responsible for any repairs and maintenance.
- Staff at the Blackbird Leys wellbeing centre raised concerns around their personal safety due to the centre being next door to the police station. When the station was unoccupied, members of the public tried to get their attention instead. Staff reported a brick had been thrown through the window and it was difficult to keep the window open in the summer as people tended to

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- A number of services had completed audits on the quality of their records. The hospital at home service, audit identified 91% compliance. We saw recent team minutes which showed the results had been discussed and action points developed.
- The nutrition and dietetics service was to review its use of abbreviations and planned to revisit their standard operating procedure (SOP) to ensure their documentation followed guidance from the British Dietetic Association (BDA) in response to a recent records audit.
- The standards of documentation audit for community nursing 2015 provided a rating of requires improvement. This reviewed only paper records. The main areas for improvement were documentation of the time of the visit, the reason why the care plan had not been agreed with the patient and the reason why the patient was unable to consent. The audit referenced principles of good record keeping (Nursing and Midwifery council, 2010).
- Some district nursing and community teams were using the subjective, objective, assessment, plan, implementation and evaluation (SOAPIE) approach when recording in progress notes, to help improve clarity. This was not consistent practice across all teams. The above audit acknowledged the challenges of consistent record keeping due to the high number of staff.
- The adult speech and language therapies (SLT) case note audit was rated good. An action plan had been produced for areas with less than 80% compliance and shared with staff.

Cleanliness, infection control and hygiene

- All clinical areas we visited were visibly clean and tidy. There was access to hand sanitiser or hand washing facilities to limit the spread of infection between staff and patients. Cleansing disinfectant wipes were provided to clean equipment, patient chairs were wipeable and clinical areas had wipeable floors for ease of cleaning.
- During home visits we observed staff adhering to the trust 'bare below the elbows' policy and there was appropriate use of personal protective equipment, such as gloves and aprons, to reduce the risk of harm to staff. Staff in general cleaned their hands prior to seeing the patient and after. On one home visit, a therapist was observed to only clean their hands after the assessment. At another, a therapist did not clean their hands at all. This placed them and their patients at risk of infection.
- Appropriate infection control measures were in place, to minimise the spread of infection to patients and staff, from patients who were seen with suspected tuberculosis.
- We saw at one location and were told at a focus group that crutches and walking sticks which had been cleaned and labelled as clean were placed next to ones which had yet to be cleaned. There was a potential infection risk to patients, as equipment was not segregated. At other locations we visited clean and dirty equipment was segregated appropriately.
- A recent infection control review by the trust had identified that all staff with patient contact should have a pocket clip for the ID badge, rather than a lanyard. This was yet to be fully implemented across services which we visited.
- The trust acknowledged that there were no set audits of infection control practices across all community services; however audits had been undertaken for six physiotherapy departments during July to September 2015. All departments had achieved a good rating (compliance of 85% or above) other than Witney physiotherapy (81%). All departments had areas to improve on, which were highlighted to the department. Areas scoring less than 85% were to be re-audited within three months.

Mandatory training

- Mandatory training for staff was via a mix of e-learning and classroom based sessions. The training matrix identified which courses staff needed to complete based on their role and grade.
- Modules included resuscitation, infection prevention and control, information governance and fire awareness.
- Staff could access the training system via the intranet to see when they needed to update their training and book training sessions. There was a phased target for each service. Team leaders could see their performance against this target, which was colour coded red, amber or green, this alerted senior staff to underperforming areas.
- Data reviewed for the last 12 months showed that not all staff had completed their mandatory training. Staff

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overall felt they had enough time to complete their mandatory training, which was confirmed by data on the training matrix. However, a team leader for the reablement service raised concerns around access to training due to short notice staff sickness, which was difficult for them to provide cover for. They told us this meant staff had to cancel training which had been booked. The trust training matrix showed a phased target of 89% for the reablement service, 72% of staff had been trained, which had been given a red rating.

- Other teams within community services for adults which showed red for the performance against target where community therapy service admin (73% against 90% target), community therapy team (central location) (77% against 88% target), chronic fatigue service (60% against 89% target) and case management (78% against 86% target).

- Records for three out of five district nursing staff in Bicester showed they had one or more mandatory training modules out of date, in some cases not updated since 2013. Staff in this team felt vacancies in their team had impacted on time to complete training.

- We saw evidence that performance on mandatory training was discussed at team meetings.

- Community therapy staff undertook manual handling training at the supplier for patient equipment, to ensure they could operate this equipment safely in a patient's home.

Assessing and responding to patient risk

- Multi-disciplinary risk assessments for patients were conducted by all staff at the first visit and were reviewed as required. We saw evidence in patient records that these assessments in general had taken place, however reviews were not always undertaken in line with guidance, or at consistent intervals. The assessments included risk of pressure ulcer (Braden tool), malnutrition universal screening tool (MUST), moving and handling, activities of daily living and falls.

- The trust audited the use of the Braden and MUST tools at the first visit for community nursing. The 2015 audit showed 92% of patients had a pressure ulcer assessment, but only 72% of patients had a nutrition assessment against a target of 100%.

- District nursing assistant practitioners scope of practice stated which risk assessments they could undertake, whether specific training and formal sign-off was

required and whether they could undertake the initial or just the re-assessment. A registered nurse would visit the patient at their first visit to complete the initial risk assessment.

- Staff referred patients to other services, if the results of the risk assessment indicated they needed specialist input. For example, for patients referred to the falls service, their home environment was considered, as well as their vision and hearing. The scoring system used showed the risk of a fall and whether an aid was needed.

- We observed three district nursing staff handovers, which took place twice daily. Patients health and wellbeing were discussed.

- The trust had introduced patient status at a glance boards in response to a review into the number of avoidable incidents, particularly grade three and four pressure ulcers. Patients identified as high risk were rated as red.

- A number of patients commented that it was difficult to contact a district nurse in an emergency, as they did not have a phone number. The district nurses in the west had just started a rapid response hub, to try and address this issue.

- For patients who required intermediate care, such as a care home, staff contacted the service directly, who considered whether the referral was appropriate and their ability to care for the patient safely.

- Staff used the alert system on the electronic recording system to record immediate risks, both medical and social for patients. This included recording of key codes to enable staff to access patient's homes. This meant that all staff had access to this information to help ensure both theirs and the patient safety

- Staff we spoke with had received training in cardiopulmonary resuscitation (CPR) and were aware of the procedure for getting assistance in an emergency.

Staffing levels and caseload

- Concerns about staffing were raised by all teams. The main concerns were vacancies and issues around retention of staff. Staff also raised concerned about consistently being in negative capacity (patient demand exceeds staffing) even if fully staffed. This was reported by staff to be because of the increasing demand for services and increasing complexity of patients, meaning assessments and care took longer.

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- The increased demand had impacted on staff morale and wellbeing, which was reflected in the most recent trust staff survey and district nurse survey. Staff told us they were asked to work additional hours but were too tired to do this. Staff also said they felt task rather than care focused. Capacity issues were also frequently reported as a contributory factor in investigations into pressure ulcers.

- The trust reported that the total vacancies for community service as of May 2015 were 93, against a total establishment of 808. There were 15 whole time equivalent district nursing vacancies across six localities, 10 of these vacancies were in the south west team, resulting in a vacancy rate of 23%. Vacancies in this area were on the directorate risk register with mitigating actions in place, including the use of agency staff.

- The district nurses used a capacity tool to establish the number of staff needed based on the number of units required for a task. One unit equated to 20 minutes. Issues around negative capacity, where patient demand was greater than staffing capacity, were addressed by sharing workload across teams in an area.

- Despite measure being taken to share workloads, demand was still not being met. Data for the central district nursing team (total of 10 teams) showed they were staffed to a total of 1814 hours under capacity over the three month period (June to August 2015). This approximated to a loss of six hours care per team per day. Staff told us the negative capacity impacted on the time they could spend with each patient or the number of visits to a patient in a week.

- Two nursing teams told us they used to report staffing shortages as incidents on a weekly basis, but had stopped, as there had been no response from senior management. We saw team minutes reminding staff to report any capacity incidents which affected patient care such as late administration of medication or cancelled visits. The trust told us that data on additional hours worked by staff was not formerly collated, although internal service reviews did confirm that staff worked extra hours.

- The total hours of cover provided by the district nursing service had been reduced in response to capacity issues. The team now worked a one shift pattern with evening cover now being provided by the hospital at home service. This team supported patients with urgent nursing needs. A safe staffing matrix was in use by this service to ensure it could meet demands for district nursing cover and its own service. The matrix showed agreed, minimum, unsafe and critically unsafe staffing levels and action to take, if these levels were reached. Overnight support was through the out of hour's service. The integrated locality teams also supported the district nursing service. A number of staff told us they were trying to fill gaps in other services, but without any additional staff.

- The trust were planning to increase the number of band six nurses due to the increasing complexity of patients and develop further the role of the assistant practitioner to support the district nurses. Senior staff told us discussions with the clinical commissioning groups were ongoing to match staffing to caseload.

- To help meet capacity some teams had started to use agency staff. Agency staff we spoke with felt their induction had been sufficient and they could access all trust systems to ensure patient safety. Two out of three agency staff had received a period of supervision prior to seeing patients.

- The respiratory team was fully staffed but staff had a current caseload of 65 patients, against a local recommendation of 50 patients due to increased demand for the service.

- The phlebotomy service sometimes had to delay blood tests or ask for support from district nurses when they exceeded their capacity. They completed incident forms when capacity affected patient care.

- The reablement service had a 19% vacancy rate at the time of the inspection. The service was also affected by a delay in the provision of care packages. This meant patients accessed the service for longer than originally planned. Staff in this team were sometimes supported by healthcare assistants from the integrated locality team. Staffing for this service was rated as an extreme risk on the integrated locality teams risk register. Weekly meetings took place with human resources and managers to proactively manage recruitment and retention. This included reviewing rates and reasons for staff sickness, to ensure staff felt supported.

- Each integrated locality hub had a daily meeting to identify which services had capacity and who was on duty, across district nursing, reablement service, community therapy and community mental health. This

Are services safe?

information was collated county wide and shared with relevant services, including the single point of access (SPA) team so referrals could be triaged and actioned appropriately.

- Therapy staff expressed concerns around increasing patient demand for specialist services, such as the physical disability and musculoskeletal physiotherapy services, adult speech and language service (SLT) and chronic fatigue service. The current staffing for these services was causing long waiting times for initial appointments. The vacancy rate was 44% for the community therapy team in Wallingford. Additional staff were being recruited to the SLT service and agency staff where used by some but not all therapy teams to reduce the wait for first appointments. Staff told us and we saw on the integrated locality team risk register, that it was difficult to recruit staff, due to the specialist nature of these services and the high cost of living in Oxfordshire.
- We saw rotas which showed that general therapy input was available to patients at weekends, through a county wide service.

Managing anticipated risks

- Community teams had contingency plans in place in case of adverse weather conditions. These identified the location staff should work from based on where they lived, rather than where they normally worked. Community nursing staff told us that they walked to visit patients, to ensure patients received care or medications.
- Staff described how they had supported patients during recent floods, for example, by visiting two venues residents had been taken to, providing medication to patients on insulin. They also kept a record of where patients were temporarily moved to, so that community nursing teams could still support those patients.
- The trust submits an annual winter pressures action plan, which is discussed by the Oxfordshire and Buckinghamshire system resilience group (SRG). The trust quality report for 2014/15 identified a co-ordinated response to winter pressures, by all providers, that had enabled more patients to be supported at home. The hospital at home service raised concerns around the impact of winter pressures on their service and their ability to continue to support the district nursing service in the early evening. This was rated red on their risk register.
- Staff were made aware of medicine or equipment safety alerts and changes to National Institute for Health and Care Excellence guidance (NICE), through emails, updates to trust intranet pages and information displayed at their office. Staff were required to sign to show they had read the update and were aware of changes which may be needed to their practice.

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.

We rated effective as ''good''.

Staff provided care to patients based on national guidance, such as National Institute for Health and Care (NICE) guidelines. Care plans were evidence based and outcome goals patient centred. Patient outcomes were monitored and reviewed by individual services.

Staff were competent for the roles they undertook and there was evidence of appropriate supervision in place for staff. The majority of staff had received an appraisal in the last year.

Patients pain needs were assessed and managed appropriately; however, there was inconsistent recording of this in patient records. Not all patients had a nutritional assessment at their initial visit to enable risks to be identified and managed, or a referral made to the relevant service.

There was a good use of assistive technology to support patients and enable them to remain in their own home for their care.

There was excellent multi-disciplinary working. Staff worked collaboratively to understand and meet the needs of patients, particularly those with long-term conditions.

There were appropriate systems and processes in place for the referral, transfer and discharge of patients from services. Staff did not all use the same electronic records system , which meant time was taken uploading information to ensure staff had access to all the information they needed to care for a patient.

Consent was sought from patients prior to care or treatment being provided. Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Evidence based care and treatment

- Staff provided care to people based on national guidance, such as NICE guidelines and guidance from the relevant professional body.
- NICE guidelines on the prevention and management of pressure ulcers had been used to develop the pressure ulcer care plans. Guidance on carrying out a lower limb assessment, referenced current guidelines from NICE on Lower limb peripheral arterial disease: diagnosis and management.
- The chronic obstructive pulmonary disease care bundle and asthma care bundle referenced guidance from the British Thoracic Society (BTS). Their guidance was also used in the planning of the pulmonary rehabilitation course.
- The home oxygen service had changed its practice around assessment of blood gases, in response to recommendation from the BTS. This was now undertaken in the patient's home using portable equipment, rather than the patient having to attend a hospital appointment.
- Guidance from the parenteral and enteral nutrition group (PENG) was used by staff from the home enteral feed service to devise suitable forms for patient assessment and guidance on treatment.
- The directorate submitted a monthly NICE guidance report. A gap analysis was taking place to establish which NICE guidance services should be using and whether practices were reflective of this. Each month new guidance was reviewed and identified to the relevant service lead to implement this. For example, guidance on acute heart failure: diagnosing and managing acute heart failure in adults was allocated to the lead for the heart failure service.
- Notes that we reviewed showed outcome goals, were personalised for the patient. The falls prevention service report 2013 to 2015 identified their service was not meeting NICE guidance as its exercise programme only ran for six weeks not 15 weeks. This was due to a reduction in classes and places and increasing demand for the service. A funding proposal had been submitted for consideration that would enable them to increase the service provided.
- The bladder and bowel service audit on compliance with NICE guidance on the management on urinary incontinence in women 2015, showed excellent compliance with six standards and good compliance with one standard. This was an improvement from the last audit conducted.

Are services effective?

- Staff did not show any discrimination when planning people's care and supported people who had reduced capacity to make decisions.

Pain relief

- Patients told us that they were asked about any pain they were experiencing and steps were taken to manage this. They said nursing staff tried to make them as comfortable as possible. Patient's pain monitoring and recording varied across the community services. We did not see consistent use of formal records of pain assessments and monitoring in the patient records that we reviewed.
- Staff working in the care home support service used the Abbey pain score to assess the pain needs of patients living with dementia, who were unable to tell staff about their level of pain.
- Some physiotherapists were trained in acupuncture, to provide support for patients they saw in the musculoskeletal physiotherapy service.

Nutrition and hydration

- Patients nutritional and hydration needs were assessed using the Malnutrition Universal Screening Tool (MUST). The trust reported in its quality report 2014/15 that nutrition and hydration care needed to improve.
- The district nursing documentation audit (2015) showed that 72% of patients had a MUST score recorded at their first visit, against a target of 100%. Patients were potentially put at risk as their nutrition and hydration needs were not being assessed or responded to.
- The malnutrition care plan advised staff to refer patients to the nutrition and dietetic service if there was no weight gain. Staff from this service felt they were often contacted too late by other services, and their input should have been sought earlier. Staff were considering running training sessions to raise awareness of their service.
- Patients identified with swallowing problems were referred to the speech and language therapy team (SLT); however, this team was struggling to meet demand for swallowing assessments, for non-stroke patients. The trust had successfully sought additional funding so they could plan to provide a dedicated service for this patient group.
- Other services also completed a MUST assessment as part of their initial visit, including the heart failure service, nutrition and dietetics and hospital at home.

- Staff from the hospital at home team told us they used a different MUST assessment form to the district nurses. They felt it would be easier if all services used the same form to ensure consistency in how information was recorded.
- The home tube feeding service, worked closely with patients and carers to consider the best feeding regime, also advising on how to access feed and supplies from the supplier.
- A nutritional action group had been set up by the nutrition and dietetics department to support patients and their families to maintain better nutritional health.
- Reablement staff received training on food hygiene and helping patients with eating and drinking as part of their induction programme.

Technology and telemedicine

- Assistive technology such as movements sensors, memory alarms tracking devices and pendant alarms were widely used to support patients to remain and be cared for in their own home. An assistive technology course was accessible to staff through the local county council so they were aware of devices that could be used.
- In response to feedback from patients, the diabetes service was planning to link with an online service, which would enabled patients to upload relevant data, to be able to self- manage their condition and have greater independence. Data was to be shared between patients and the diabetes service to enable targets and goals to be set. The programme was accredited against NICE guidance.
- The heart failure service told us they were considering the introduction of video messaging to enable patients to attend their appointment virtually, where appropriate.
- The reablement service and three other services had trialled the used of the 'just checking system' which provided information on patient mobilisation and falls so suitable levels of care were provided. The trial had identified potential improvements which could be made to referrals to these services.

Patient outcomes

- Most of the services we visited collected and reported on patient outcomes at local meetings. This was through analysing whether individualised goals were achieved or not, or by use of standardised patient

Are services effective?

reported outcome measures (PROMS). We did not see evidence in the monthly directorate quality report or from the minutes we reviewed that this outcome data was considered or discussed at senior team meetings.

- The musculoskeletal (MSK) physiotherapy service reported on clinical improvement using the patient specific functional scale (PSFS). Patients were asked to rate their ability to perform certain activities before and after treatment. Data for June 2015 showed 84% of patients showed a clinically significant improvement against a target of 80%. Patients were also asked through the patient questionnaire, to rate their level of pain and the percentage improvement since referral. No data was provided on this.

- The pulmonary rehabilitation team evaluated the percentage of patients with a clinically significant difference for the shuttle walk test, before they started the rehabilitation course and after. This looked at how long a person can walk between two targets keeping in time with an auditory beep. Their target was 60%, data for the period April 2015 to August 2015, showed they achieved this target or better for all but one month. Patients on the course told us they found it helpful to have a record card so they could see the improvements they were making each week.

- The service also asked patients to report on their exercise tolerance and quality of life at the end of the course. For 170 patients, 155 scored their exercise tolerance as better or slightly better. For the same group 137 scored their quality of life as better or slightly better.

- The chronic fatigue service had introduced a nationally used programme to enable patients to create their own individual pathway to recovery. Patients benefitted from group support and co-exploring care options with clinicians rather than being advised by the clinician what was most appropriate for them.

- The reablement service had a target of 50% of patients achieving independence. Data was reviewed monthly and showed for April 2015 to September 2015 that this target was met or exceeded every month.

- Community services participated in local and national audits. Outcomes and actions were discussed at team meetings and reported on in the directorate monthly quality report.

- The trust participated in the national audit of intermediate care 2014. This national audit looked at the provision of intermediate care for patients who had been discharged from hospital or avoided unnecessary

admission to hospital. The trust reported that the audit showed the reablement service was operating efficiently. No targets were set for this audit and comparison with equivalent sized services was not possible, although the trust could see its performance was above (better than) the national average in a number of areas. The national audit concluded that intermediate care services were not expanding at a sufficient rate to meet current capacity, which was contributing to delayed discharge of patients from hospital. The older people directorate leads met regularly with other relevant service to develop an action plan to improve delayed transfers of care

- The trust also captured data on the number of avoidable emergency admissions to hospital as part of the NHS commissioning for quality and innovation scheme (CQUIN). Performance to the set target created additional income for the trust

Competent staff

- Staff in all services told us they had good support from their manager through one to one meetings and an annual appraisal, where learning needs were identified. The trust guidance recommended a one to one meeting for staff every six to eight weeks. One to one meetings took place more regularly in some teams, such as district nursing. Staff told us time for these meetings was affected by patient demand.

- Managers told us they checked the registration status of staff in their team to ensure they remained fit to practice.

- Data from the trust on completion of appraisals for community services for adults, showed variable compliance with the trust target of 100%, despite positive comments from staff. Four out of 39 teams, within community services for adults showed compliance of 60% or under, case management, district nursing (south west), reablement service and community therapy (Witney).

- Clinical supervision was in place across most teams. This took the form of peer-to-peer review of notes, supervision whilst seeing patients and group case discussions. These were led by a more senior member of staff, sometimes from a different location, to enable staff to ask questions more openly. Any capability concerns were discussed with the staff members' manager.

Are services effective?

- Clinicians from the integrated locality service found it hard to access support as colleagues worked countywide. Support staff for this service received supervision from rehabilitation staff, based at the integrated locality hub.
- New district nurses had a two-week induction programme, which staff told us was thorough and well organised. Sessions were provided in the trust clinical skills lab, which had a mock home environment to simulate performing tasks in a patient's home. Band five staff initially had weekly supervision. Agency staff had access to induction and supervision.
- Reablement staff had a five-day induction programme which covered mandatory training, but also person centred care and dementia awareness. The staff were competency assessed for use of equipment in patients' home by occupational therapy staff.
- We saw evidence of competency based training for district nurses, including pressure damage prevention, pressure ulcer management and diabetes management. Registered staff were required to self-assess their level of competency and then discuss with their manager. All non-registered staff in the district nurse service were required to be formally signed off in the competencies, by an experiences registered nurse. The assistant practitioner district nurse training programme was also competency based. The falls service had a specialist training programme in place for new starters.
- Staff from continuing healthcare followed a novice to expert training programme to enable them to undertake a needs assessments with patients and their families
- A manager for the reablement service told us it was sometimes difficult for staff to attend planned training days due to patient demand for their service. Staff in the nutrition and dietetic service found it difficult to find the time to undertake additional training for their role.

Multi-disciplinary working and coordinated care pathways

- Patients told us, we saw evidence in notes and observed in practise good multi-disciplinary team (MDT) working across all teams to enable good quality patient centred care. Staff also commented on the strength of the MDT working and how this provided effective care and treatment for patients.
- The introduction of integrated locality teams and hubs had developed MDT working. Staff told us patients were referred more quickly to other services and MDT case

discussion for complex patients were easier to facilitate. Patients with long- term health problems benefited from services working together and avoided admission to hospital where possible. Staff had a better understanding of what each service did.
- The integrated locality teams included staff from social services and mental health enabling all staff to work together to deliver a holistic package of care for patients from one location.
- We saw routine referrals made directly to services via use of referral forms. The single point of access team (SPA) assessed patients with more complex or escalating needs. They received referrals from GP's and other healthcare professionals. They triaged referrals and contacted the relevant service directly or requested input from the integrated locality team's service, who visited the patient to assess the most suitable service for them. The trust planned to review the pathway process used by the SPA service and integrated locality teams to avoid duplication. Staff from the integrated locality teams service; felt their role was not fully understood by other staff. There was further complication in regards to terminology, as staff worked in integrated locality teams and within this was the integrated locality team service.
- The SPA caseload audited in 2015 looked at the extent to which the service avoided hospital admissions and effectively managed long-term conditions in the community. Eight patients out of 3245 were recorded as being an acute admission; all other patients were managed by services within the older people's directorate. Ninety nine percent of referrals were completed within 48 hours. Nine patients out of 3245 waited longer than this, there were no recorded consequences to these patients, who were seen outside the target time. No specific actions were planned due to the outcomes from the audit.
- Staff told us they conducted joint home visits to patients to co-ordinate care pathways. For example, the tissue viability nurses or heart failure nurses would visit with the district nurses.
- The physical disability service worked with a number of voluntary organisations and charities to support patients with long-term and progressive neurological conditions. These groups offered support networks and additional exercise classes to encourage self-management and maximise independence.

Are services effective?

- The continuing health care service worked with CCG's and all MDT staff to discuss whether a patient met the criteria for eligibility for the service and the best location for a patient to receive their care.
- Minutes from a recent hospital at home team meeting showed they planned to link with leads from all services, to remind staff of the patients they could support, to prevent hospital admission or facilitate discharge.
- Staff from the care home support service, which included nurses, mental health, falls team, physiotherapists, support workers and consultants told us they worked well as an MDT, holding weekly meetings to discuss patients.

Referral, transfer, discharge and transition

- Patients who had escalating needs were referred to the integrated locality service or the hospital at home service. They provided short-term care at home and avoided admissions to hospital or intermediate care beds, whenever possible.
- Staff who worked in the south raised concerns that referrals from hospitals in Berkshire did not always contain all the relevant information and they could not access the patients' records. Staff tried to obtain this information from the discharging ward or department.
- An administrator at the integrated locality team's hub told us that referrals were not always captured electronically as clinicians sometimes referred patients to another service verbally. This made it hard for administrative staff to follow up on referrals, if a patient or GP contacted them.
- Services had set criteria for the patients they would accept. If the referral was not accepted, they would write or speak with the referrer to explain the reason why. The district nursing service did not see patients who were able to attend their GP surgery and be seen by a practice nurse.
- There were transition arrangements in place to support young people, who needed care, as they moved from children and young person services to the district nursing team. These arrangements had been developed in response to complaints from parents about the lack of continuity of care. Since the change, no further complaints had been received.
- Nursing services would meet with the young person and their family to discuss their care needs and to smooth the transition between services. We were told an MDT meeting would be held to see how these care needs could be met and where gaps remained, these were actioned in good time.
- The patient pathway for people at home who required enteral feeding gave clear guidance as to when to consider discharge from the service.
- Community staff attended discharge planning meetings at the local acute hospital so ongoing care was in place before a patient was discharged. The reablement service had daily telephone calls, with the supported hospital discharge team from the acute trust to discuss capacity in their teams. Delays in people accessing long-term domiciliary care packages, affected patients being discharged from hospital to the reablement service.
- This partnership working was also in response to a complaint, which identified that the quality of referrals and transfer information from the supported hospital discharge service to this team needed to improve.
- Once a patient had been discharged from a service this was documented in their electronic record. A letter was sent to the patient's GP, with a copy to the patient and uploaded onto the electronic record. Staff were aware that the trust record keeping policy required letters to be sent within 10 days of discharge.

Access to information

- Staff raised concerns and frustration around multiple electronic records being in use and not all staff being able to access each system . Reablement support staff used a different system to trust staff. The trust was moving to a new electronic care record shortly after the inspection.
- Staff spent time uploading information across systems to ensure all teams could access information in a timely manner to deliver effective care and treatment.
- Some patients were cared for by the acute trust and/ or social services. Their electronic record systems did not link with the system used by the trust. Staff had to type this information into the patients' record or scan in letters received.
- Admin staff for the speech and language therapy service had access to two electronic systems so they could access information on patients seen in the acute trust and referred to community services. This saved therapists having to spend time contacting the referrer for information.

Are services effective?

- Staff in the nutrition and dietetics department had a continuity plan in place during the transfer to the new records system. Copies of patients' records were to be printed from the current system. An administrator in another service felt uncertain on the continuity plan for their team, nothing had been discussed with them. They had received training on the new system.
- Staff from teams who conducted home visits told us the internet connection was not always maintained so they could access the electronic record. They would make paper notes and then upload this information once back at a trust office. The paper information was then shredded. Staff were not assured that connection issues would be resolved with the new electronic record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment. Verbal consent to treatment was recorded in the patients' records. The district nursing records audit had identified this as an area for improvement. We saw in two out of 16 records that consent for treatment had not been recorded, as set out in the trust consent to examination or treatment policy (2012).
- Staff told us and we saw evidence in their training records that they had completed Mental Capacity Act

(2005) training. The directorate target was 90% compliance with this training. For community physical health services, this target had not been achieved for the four months (May to August) 2015). Average compliance was 84% over the same period.

- Staff were aware of the responsibilities to complete a mental capacity assessment for patients unable to give consent. However, staff told us that they did not have access to a standardised form to document this. Staff would contact the safeguarding lead nurse if they had any concerns around how best to support a patient.
- A member of the community therapy team described appropriate use of a best interest assessment to provide care to a patient who was unable to consent to provision of a location tracker.
- A district nurse told us they considered the most appropriate time to visit a patient who had fluctuating capacity so the patient could be involved in decisions around their care as much as possible. Nursing staff told us patients may use gestures to indicate consent and staff would look for non- verbal cues.
- The referral process for the continuing healthcare needs assessment specifically asked whether the patient was able to consent to sharing of information and if not had the decision been made in line with the MCA. This could be either through a best interest decision or consent from an individual with a lasting power of attorney.

Are services caring?

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

We rated caring as ''good''

Feedback from patients and those close to them was consistently positive about the care they received and how staff treated them. Staff treated patients with dignity and respect and were observed to be compassionate, caring and understanding.

Patients we spoke with felt active partners in their care. They had a clear understanding of their condition, care plan and treatment goals. Staff spent time talking to patients, ensuring the information was presented in a way the patient could understand.

Staff were seen to be responsive to patients' physical and emotional needs. Staff across all community teams showed empathy and kindness and supported patients to cope emotionally with their care and treatment. Group exercise sessions were held so patients and carers could develop support networks. Voluntary organisations assisted in maintaining people's independence, through running advice sessions and offering support.

Detailed findings

Compassionate care

- All patients we spoke with praised the quality of care they received from staff. They told us staff were professional, courteous, polite and patient. One patient commented '' I am absolutely satisfied with the service I am getting'', another told us ''the service I receive is excellent''. During home visits, we observed staff interactions with patients to be friendly but respectful.
- Patients spoke of the compassion shown by staff and how staff were always obliging and would support them to address their needs.
- Patients felt the care they received was safe. Staff were easy to talk to and listened when they raised concerns. One patient raised concerns around the speed of her visit, due to the number of patients that staff had to see.
- Three patients specifically commented on how new staff always took the time to introduce themselves.

- Throughout our inspection, we saw patients being treated with respect and their privacy and dignity maintained whilst care was being provided. Staff were mindful of their approach when providing care to a patient of the opposite gender.
- The results of the Friends and Family Test data demonstrated overall that patients would be extremely likely or likely to recommend the service they were seen by to friends or family. This was consistent for all community health services for adults. Feedback comments were positive and highlighted the clinical excellence of staff.

Understanding and involvement of patients and those close to them

- Patients told us and we observed, clear explanations being given, about their care plan and treatment. Patients and those close to them were actively involved in decisions about their care and were told when changes were needed to their care plan or goals. Patients felt informed at all stages of their treatment.
- Patients said they were given sufficient verbal and written information about their care and treatment. They had confidence in the information that was provided by staff.
- Patients were always provided with the opportunity to ask further questions at the end of their assessment, both during home visits and at outpatient clinic appointments. Patients felt they were listened to and could express any concerns they had.
- We observed two patients with pressure ulcers being given advice on skin repair, wound healing, and suitable pressure relieving equipment. This meant they were actively involved in their care and were aware of changes they could make to aid recovery.
- A patient told us '' they had one to one service from staff, they felt an individual''.
- Patients cared for by the district nurses in general knew how to speak to a member of staff in an emergency or who to contact outside the normal working hours of the service. We observed a patient being given all relevant contact details as part of their first visit by the district nurses.

Are services caring?

- We saw a district nurse making short notes for a patient about their treatment plan to help them remember when to take their medication and so they could discuss their care with their family.
- Patients supported by continuing healthcare were allocated a personal health budget. This enabled them to have their say in how the money was allocated, to ensure their health and wellbeing needs were met and care delivered as they would choose.
- Nursing staff in the tuberculosis clinic supported non-English speaking patients to be involved in their care through use of a telephone interpretation service. This was particularly important due to the complex nature of their treatment plan.

Emotional support

- Patients spoke of the empathy which staff showed, particularly patients who needed long-term support. Patients valued having the same two or three members from the district nursing team providing their care. A patient commented '' on the excellent relationship with the team, they know me well''. Another told us '' I rely on them, they are there for me''.
- A patient who was receiving step down care, received a phone call daily to ensure their care needs had not changed and the patient was still maintaining their current level of independence.

- During a home visit, we observed a carer being given support and advice on services they could access to support them.
- Another carer told us '' I could never have managed without them (district nurses), they have been here at every stage''.
- We saw in a patient's care plan that their carers had been trained on positional changes and this was included in the care plan.
- The physical disability physiotherapy service and the pulmonary rehabilitation service ran group exercise sessions, which enabled patients and carers to offer support to each other. Patients at a pulmonary rehabilitation class told us they felt encouraged, well supported by the group and could see improvement in their overall wellbeing.
- The integrated locality teams and the reablement service worked with voluntary organisations to provide support to patients. This included a welcome home package for patients who had been discharged from hospital and a project to support people to be involved with activities in their local community, to reduce isolation and loneliness and build relationships.

Are services responsive to people's needs?

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

We rated responsive as ''good''

Services were planned and delivered in a way that met the needs of the local population. Patients' were seen at home and outpatient clinics were provided countywide. Services had made changes in response to patient feedback, including access to appointments, at a time which was convenient to the patient.

Staff were mindful of the need to ensure their service was accessible for all and we saw good examples of how patients who were non-English speaking, had a disability or were living with dementia were supported. Care plans were co-ordinated across different services. Clinics were held in locations which were accessible to all.

Overall community services were not achieving the trust waiting time for referral to first appointment of 12 weeks. There were waiting lists for specialist therapy services. Patients were prioritised and seen according to need. Changes were being implemented to address the wait for appointments, such as the use of locum staff and review of the patient pathway.

The directorate were working with other health and social care providers in the area to reduce the number of delayed transfers of care. Delays in accessing long-term care packages caused delayed discharge of patients from hospital, as patients were unable to access the reablement service.

Complaints were handled in line with the trust's policy and were dealt with in a timely manner. Staff were encouraged to be proactive in handling complaints. Staff received feedback from complaints in which they were involved and learning was shared at team meetings. Most patients we spoke with felt they would know how to complain if they needed to.

Detailed findings

Planning and delivering services which meet people's needs

- The Joint Strategic Needs Assessment (JSNA) annual summary report 2015 looked at trends in the health and wellbeing of the local population and assessed changing patterns of need and demand for services. The report identified the population in Oxfordshire would continue to grow, with a 23% increase in those aged 65 and over in the next ten years, further impacting on services, particularly timely discharge of patients from hospital. The trust acknowledged the findings of this report in its two-year operating plan and the need to work closely with other health and social care providers.

- Senior management were working with other health and social care providers to develop a supported discharge policy which was to be used across all services. The trust had completed two breaking cycle weeks, to try to identify different patterns of working to address delayed transfers of care. Learning from these had yet to be implemented, but included greater use of multi-agency case conferences to discuss patients affected by delayed transfer of care.

- The reorganisation of services to integrated locality teams had improved patient access to support not just for their health needs, but social needs as well. All community services contributed to meeting the needs of people with long-term or life-limiting conditions to keep patients out of hospital.

- Patients seen by community services were generally seen in their own home. Where clinics were held, these were held county wide, predominantly at local community hospitals, with some clinics held at local health and wellbeing centres or GP surgeries, to enable patients to access care locally. Car parking was difficult at Abingdon and Townlands Community Hospitals, which affected both patients and staff.

- The pulmonary rehabilitation courses took place at local leisure centres to enable access to exercise equipment and group education sessions in one location. It also increased accessibility for people who did not have access or were unable to pay for transport and could not get to the hospital. No funding was available to support people to attend the course.

- The pulmonary rehabilitation course included sessions from physiotherapy, respiratory nurses, nutrition and dietetics and occupational therapy to enable patients to access multiple services at one location.

- The nutrition and dietetic service responded to patient feedback by starting some clinics earlier and offering later appointments. They had also introduced home

Are services responsive to people's needs?

visits for patients unable to access clinics. This service was appreciated by patients, but had affected administrative time for staff, as no extra staff had been provided for this service.

- The tuberculosis service conducted screening sessions at schools and universities in the local area, to target their service to relevant population groups.
- The district nursing service hours had been reduced to ensure a safe service, with additional hours covered by the hospital at home team and integrated locality team service.
- The falls service told us that a lack of a service level agreement for locations they used affected access to rooms or required them to find a different location to run the clinic, as the provider needed to use the room.

Equality and diversity

- Staff told us how they planned services to ensure they were accessible to all. This included holding clinics at locations which were accessible to people with a disability. This was evidenced during our inspection.
- Adapted exercise bikes were provided at some leisure centres to enable people seen by the physical disability service to continue with their rehabilitation programme locally. There was joint working between staff from this service and at the leisure centre.
- Most patient information leaflets included information on how to access the information in another format such as easy read, braille and languages other than English. This statement was written in seven different languages, which were reflective of languages spoken in the area. Staff knew how to access interpretation services and where possible avoided the use of family members to translate at appointments, to ensure accurate and independent translation of information. The trust had a corporate accessible communications guide, which provided additional information to staff on how to access to services and support patients. This included a standard accessibility statement; this was not included on the information leaflet about the musculoskeletal physiotherapy service.
- A recent report from the Asian Women's group had identified that people valued the support given, but recommended better information on access to support for families caring for families at home. It also suggested more training for staff on culturally appropriate care packages.

- The continuing healthcare service recorded information on peoples' religion or cultural needs and considered this when planning a package of care.

Meeting the needs of people in vulnerable circumstances

- Patients with a communication difficulty or those with a learning disability or living with dementia were supported using the ''knowing me'' passport which was devised jointly by a member of staff from the care home support service and the acute trust. This captured information on a person's preferences such their normal routine, things that worried them, but also information on difficulties with hearing and mobility for example. It helped staff to deliver better person-centred care.
- The nutrition and dietetic service and tuberculosis service provided a service to people in prison who could not readily access the service.
- A pictorial contact sheet was to be introduced by a district nursing team for patients with literacy difficulties, to ensure patients contacted the correct person if they had a concern or question.
- Staff had an awareness of how to support people living with dementia. Staff felt this was an area where they lacked knowledge and not all teams had access to a dementia specialist nurse. This was supported by directorate training data which showed 65% compliance with dementia training against a target of 90%.

Access to the right care at the right time

- The trust collected data on waiting times for initial assessment, did not attend (DNA) rates and cancellation rates for all services offering outpatient appointments. This was reviewed at a local level but not reported on as part of the quality dashboard for the directorate, to ensure targets were met.
- Staff running specialist services for patients, such as musculoskeletal physiotherapy service and physical disability physiotherapy, expressed concerns around waiting times for initial appointments, the safety of people on the waiting list and the team's ability to provide an effective service. They told us demand for services exceeded staffing levels, even in teams with no staff vacancies. Staff prioritised referrals they received and sometimes community physiotherapists saw patients to provide quicker access to appointments.
- The musculoskeletal physiotherapy service waiting times position paper (September 2015), reported that

Are services responsive to people's needs?

from April to July 2015, the trust target of 95% of patients being seen for their first appointment within 12 weeks was not met. The average was 82% of patients were seen within 12 weeks. The service was rated high risk on the directorate risk register, with additional funding provided by Oxfordshire CCG, who acknowledged the service was underfunded. Locum staff were being recruited to manage the immediate waiting list backlog, with ongoing work to standardise the service to reduce inefficiencies and inconsistencies. A proposal had been submitted and agreed in principle with stakeholders to redesign the patient pathway for this service.

- Staff from the physical disability physiotherapy service described a patient who had developed a lesion on their hand, which was initially missed by care staff. They felt delay in access to their service had contributed to this incident, which was reported and investigated. They told us the waiting time for a first appointment was 16 weeks. Their aim was to see all new patients within six weeks, the trust had not set a waiting time target for this service. They told us they were funded for 620 patients, but last year saw just over 1000 patients. Data from the trust showed that for September 2014 to August 2015, an average of 70% of patients were seen within 12 weeks for this service.

- Speech and language therapists (SLT) told us that they were breaching waiting times for swallowing assessments for non-stroke inpatients and for patients requiring access to community services. Data provided by the trust showed that from September 2014 to July 2015, the majority of patients waiting for a routine communication assessment had to wait 16 weeks or more. In the same period, the majority of patients needing a routine swallowing assessment waited between 12 to 16 weeks for an appointment. SLT staff triaged community referrals based on patient need, with patients seen within six, 12 or 18 weeks. Funding had been received for the recruitment of eight additional SLT therapists to work across the service to address waiting times and support the introduction of a rapid response dysphagia (swallowing) assessment team. This service would be run seven days a week.

- The average waiting time for an appointment with the district nurse across all locations was six days for

September 2014 to August 2015. The district nursing service had responded to a patient feedback and now asked whether a patient wished for their visit in the morning, afternoon or had no preference.

- Within the integrated locality hubs, there was a duty lead for the main services. They triaged and actioned urgent referrals for their service. Staff told us this system worked well and meant they could focus on seeing booked patients.

- Core services such as single point of access, district nursing, community therapy and reablement operated seven days a week. Staff felt this helped to avoid unnecessary admissions to hospital.

- The continuing health care service had a target of 48 hours to undertake an initial assessment and to complete a full needs assessment, for eligible patients within seven days. Staff verbally told us the average for this assessment was 10 days. No written data was available. Staff raised concerns that delays in accessing their service contributed to delayed transfers of care (DTOC) of patients from hospital or the reablement service. Some people had to access care out of county on an interim basis, whilst waiting for their preferred place of care. The patient and their family were always consulted first.

- The reablement service in the west, advised on the day we visited, that 29 long-term care packages were needed across the county causing discharge delays. Patients continued to be supported by the reablement service, to ensure their care needs were met, although the reablement service was a short-term service. This affected new referrals being accepted by the reablement service, which delayed discharge of patients from the community and acute hospitals.

- Snapshot data on DTOC from in-patient wards for week ending 27th August 2015, identified the three main causes for DTOC with the highest lost bed days (prevent admission of a new patient), were awaiting care package with therapy support from reablement service, access to care in a nursing home and patient preferred choice of care home not available.

- Some outpatient services were linked to the 'choose and book' system to enable patients to choose a time for their appointment, which was convenient for them.

- Three patients told us that their next appointment had been sent in the post. They would have preferred to

Are services responsive to people's needs?

book their appointment as they left, to ensure it was at a time convenient for them. One patient commented that running combined nurse and consultant led clinics would reduce the number of visits to hospital.

- The average DNA rate was 9% across all community services for the period August 2014 to July 2015, the lowest DNA rate was 6% for respiratory services and the highest 13% for bladder and bowel. The musculoskeletal physiotherapy service and nutrition and dietetics service had introduced changes to encourage patient attendance and increase appointment availability. A number of community services sent text message reminders to encourage people to attend appointments.

Learning from complaints and concerns

- The trust captured data on formal written complaints by ward or team. This data was reported on as part of the monthly quality report for the directorate. The percentage of complaints responded to within the agreed timescale was also reported, however, this had only been reported on for three out of 12 months during the last year.
- For the period April 2014 to May 2015 there were a total of 23 complaints for community services for adults. Of these 11 were upheld by the trust. One complaint was referred to the Ombudsmen and upheld.
- Nine complaints were received for the continuing healthcare service. These were mainly around the decisions which had been reached around eligibility for NHS funded care or the time for the service to reach a decision. Where the patient or family did not agree with the decision, they were provided with information on the formal appeals process. The department kept data on the number of successful appeals and learning shared with staff.

- Complaints were investigated by the relevant local team and only referred to more senior management, if the severity of the complaint required it be reviewed by a more senior member of staff. An action plan was produced which was either for trust wide or directorate level learning. This contained a recommendation, action and target date for completion. Managers told us they would speak with the complainant and write to them with a summary of the investigation and outcome.
- Learning included linking with the dementia care lead for patients from the bladder and bowel service, who were living with dementia, for support on managing continence issues. In another example, a patient was to be provided with a named senior district nurse, when this nurse was not on duty they were to be visited by another senior nurse from the same team.
- Staff told us they would try to resolve a complaint informally first, but were aware when they needed to escalate the complaint to their manager.
- Patient information leaflets advised how a formal complaint could be made, by speaking with a member of the patient advice and liaison service. Some patients told us they were unaware how to make a complaint, but equally they had not needed to due to the excellent service they received. Information on making a complaint was available in patient notes, for those patients cared for in their own home.
- The community therapy service (north team), collected comments from patients and with their permission displayed them so staff could discuss points which had been raised. We saw evidence from minutes that learning from local complaints was discussed at team meetings, but not shared across teams.

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.

We rated well-led as ''good''.

There was a clear vision and strategy in place for community health services for adults, with a focus on providing a safe, high quality person-centre service for patients. The strategy was reviewed to identify areas for improvements and senior managers were working with key stakeholders to achieve the vision.

There was an effective governance structure in place to manage risk. Quality performance was monitored and reported at board and directorate level, with action taken in response to areas of poor performance. There were local risk registers in use and teams discussed safety performance at their team meetings. Learning from incidents was not shared across teams or services. Audits were used to monitor performance and improve quality. Policies and standard operating procedures were in use, but we found some of these to be out of date.

All staff spoke positively about their manager and felt they were competent to perform the role. They felt well supported by their manager and other members of their team. The structure of the integrated locality teams was complex and staff did not understand all the roles. Staff did not feel information was always communicated to them, by senior management or the integrated locality leads, particularly in relation to the move to integrated locality teams or changes to services. Areas of good practice were not shared between teams and ideas to improve services were not always acknowledged. There was not cohesive working across teams, although there was good multi-disciplinary working at individual locations. Concerns were listened to at a local level.

Staff from countywide services felt marginalised since the move to integrated locality teams. Some specialist services did not feel valued or recognised by senior management.

Patient feedback was collected and used in make changes to a number of the services we visited. These included patient survey feedback and learning from complaints. There were plans at directorate level to make greater use of patient feedback forums and feedback from carers.

There were good examples of innovation to improve patient care and wellbeing. Cost improvement programmes were in use to ensure sustainability of services.

Service vision and strategy

- The directorate leads were clear about their priorities for community services for adults and had both a short-term and long- term vision and strategy. The trust's vision '' outstanding care delivered by outstanding people'' was embedded in the vision for community services, which was to provide integrated community and mental health service for patients, delivered by competent staff. There was a strong emphasis on working jointly with all sectors, including voluntary organisations, to achieve this vision. The service leads were able to discuss the challenges and risks involved with implementing the vision, particularly issues with capacity and demand.
- Staff told us they were still going through a process of transition and adjustment to new models of working due to the reconfiguration of the directorate and move to integrated locality teams, the latter of which had only been recently implemented.
- Staff frequently commented on the constant changes to service structure and management. Staff told us there were positives and negatives to the new integrated model of working, but felt patients would receive an improved service, which focused on all their needs. Staff knew their role in achieving this, but did not relate this to the trust's vison or more long-term vision for the directorate. They were still adjusting to the changes, which had taken place.
- Service reviews of the new integrated locality teams were taking place, led by the integrated locality leads, with a view to further integration of more specialists nursing and therapy services and the use of integrated care pathways across the whole of the service, from hospital to community, to develop the vision and strategy further.

Governance, risk management and quality measurement

Are services well-led?

- The trust's strategy included improving the quality of services. A quality dashboard had been in use by the directorate since October 2014. This captured data on a number of key performance indicators which enabled performance and quality to be measured and monitored. This included feedback from patients, through the Friends and Family test results and numbers of complaints and accolades received. A monthly report was submitted to the trust board and discussed with service leads.

- The complex structure of the integrated locality teams and some vacant management posts meant this information was not always cascaded to staff on the front line. This included sharing of learning from incidents and complaints.

- We saw and reviewed risk registers held by the directorate and integrated locality teams. Risks identified, such as staffing levels for district nursing and therapy services, difficulties with retention of staff, incidence of pressure ulcers, corroborated with concerns raised by staff and evidenced by our findings during the inspection. Risks were managed, actioned and rated, with review of the rating once changes had been implemented. We saw local risk registers in use by some community service teams, where these were not in place, staff told us there were plans to address this.

- Staff at a local level were aware of changes, which had been or were due to be made to their service, such as the introduction of regular clinical supervision and the use of locum staff in the musculoskeletal physiotherapy service.

- Local team meetings were often structured under the five key quality headings of safe, effective, caring, responsive and well-led. These were known as 'IC5' at the trust. This was a recent change, but staff told us it encouraged more structured reflection on the quality of their service.

- A trust wide project was taking place to review the quality of data and ensure it was accurate and reliable so that there was assurance that reporting was truly reflective of the service provided.

- Community services for adult participated in the national audit of intermediate care. Audits were also conducted locally such as quality of documentation in records. Results and action plans were discussed at team meetings. Audits were reported after three months if the audit rating was requires improvement or unacceptable.

- We reviewed a number of standard operating procedures (SOP) during the inspection, these were mostly in date. However, the integrated locality team service patient pathway SOP did not have a release date or review date. The SOP for lone working for the Abingdon district nurses expired November 2014, it was also not reflective of current practice by staff. There was no SOP in place for the recently introduced rapid response district nursing service.

- An administrator told us they had raised concerns, that there was no SOP for their service prior to the move to integrated locality teams, to identify how their service would support staff. They told us there was still no SOP in place.

- Staff told us that forms for risk assessment were not standardised across the trust, for example the hospital at home service used a different nutritional assessment form than the district nurses. There was a potential risk around data quality impacting on patient treatment. There were also two versions of the insulin care plan available to staff on the intranet

- There was therefore not assurance that all services were being carried out in a consistent manner to ensure quality and safety.

Leadership of this service

- As part of the strategy for the service, the quality of leadership was identified as an area for improvement and development. The skills team were providing leadership and management training to relevant staff.

- Staff told us that their immediate managers were supportive and approachable. Staff felt at a local level that services were well-led. Managers listened to concerns or suggestions and escalated these when appropriate. Staff did not feel these concerns or ideas for service development were always acknowledged by more senior staff nor did they receive feedback.

- Some staff in county-wide services found it difficult to meet with their immediate manager, due to staff not working at the same location. Team meetings were difficult to arrange due to distances staff had to travel for meetings.

- Staff expressed concern around the lack of clarity of the management structure for the integrated locality teams. Staff told us the structure was complex, they did not understand all the roles and there were frequent changes to staff in these roles.

Are services well-led?

- Staff from the care home support service, falls service and integrated locality team service, told us their services were not fully understood by senior managers. Staff felt their input to patients' care was not valued and services were not acknowledged by management.
- Staff reported a disconnect if their service was not based at a 'hub'. This impacted on county-wide specialist services and some district nursing teams. However, staff from speciality services were concerned with the planned move to further integration, their services would become fragmented and peer to peer support would be difficult. They did not feel managers had explained how these changes would work on a daily basis.
- The executive trust board had visited a few community services. These visits were valued by staff.

Culture within this service

- It was evident from talking with staff and during observations of home visits that the main focus for staff was providing good quality care to patients. We saw examples of staff working late, to complete paperwork as patient visits had taken longer than expected. Staff would go above and beyond to meet patients' needs.
- Staff continually worked towards helping people maintain independence and remain at home. There was a strong emphasis on avoiding hospital admission, which was embedded within the culture of the service.
- Staff expressed concern around the number of significant changes that had taken place in one year and the impact of this on staff morale.
- The minutes from the board of directors meeting March 2015, had raised concerns about sickness absence and turnover and that the trust needed to address these areas. Staff sickness rates and turnover were identified as risks on the directorate risk register. Support through one to ones and the use of agency staff to operate services closer to planned staffing levels had been introduced, to try and reduced these rates. The average staff turnover for community services for the last 12 months was 14%. Staff sickness absence averaged 5% during the same period, often due to stress.
- There was a trust wide personal safety and lone working policy. Many services we visited had a departmental policy or standard operating procedure. We saw good examples of safe systems of work in use by staff to ensure their safety and wellbeing. For example buddy systems, diary sheets with information on location and

expected return time, coded message systems to alert that help was needed urgently if a member of the team called the department. District nursing staff in Bicester however did not have such robust systems in place. Daily patient lists were available on the electronic record system, but staff did not check in or out of the office. Staff were expected to call if they were not returning to the office; it was assumed staff were safe, if they did not return to the office. There was no cross checking if staff had not made contact with the office.

Public engagement

- All services we visited during the inspection gathered people's views and experiences through use of patient feedback forms. Patients who received care at home by the district nursing service were sent a questionnaire to complete by the trust. Data was also captured through the Friends and Family test. There was a high level of patient satisfaction for the survey results we reviewed.
- Changes that had been introduced in response to patient feedback were patients preferred visit time documented by the district nursing service, and introduction of a nutritional support group run by the nutrition and dietetic service for patients and families. The physical disability physiotherapy service had introduced a six week exercise class in response to feedback for a group exercise class.
- Data on complaints and accolades for the directorate was reported on a monthly basis and shared with the board.
- The trust was in the process of improving how it sought views from patients and those close to them, through the patient experience and involvement group. This included greater involvement of patient experience and carer reference groups and moving away from collecting feedback just through patient surveys. The need to feedback results to patient and carers was also identified.

Staff engagement

- NHS staff survey results for 2014 showed the trust was not in the top 20% of trusts for any key findings. The trust was in the bottom 20% of trusts for seven key findings including work pressures felt by staff, staff working extra hours and feeling satisfied with the quality of care they provide to patients.

Are services well-led?

- Data on the staff Friends and Family test was also collected by the directorate; this showed 54% of staff would recommend the trust as a place to work.
- A directorate specific action plan had been devised in response to the directorate staff survey results. This had yet to be fully implemented
- A separate staff survey had been completed for district nurses. This identified higher levels of satisfaction for staff working in the north, north east and west. Staff from the south and central areas reported more concerns. These were areas with higher vacancy rates, which affected time for one to ones and appraisals. For all areas there were concerns about the impact of working extra hours on staff wellbeing.
- Staff told us they did not feel fully informed prior to the move to integrated locality teams. Staff did not feel there was enough consultation or opportunities for them to raise concerns or make suggestions. Staff told us things were getting better and one staff member said '' it feels on the cusp of something good''.
- Staff told us about changes they had introduced in their teams, which would benefit colleagues, but these ideas were not introduced across all services, for example the patient caseload management tool, used by district nurses in the west of the county. A number of teams told us there seemed a blockage to sharing of ideas.
- Staff were recognised for their work through the trust staff recognition awards. A number of teams within community services for adults had been nominated or won an award, including nutrition and dietetic service, care home support and home oxygen service. A district nurse had also won a national award for their work, which was reported on and acknowledged by the board of directors.
- An online forum was used by district nurses for sharing of information and for feedback and ideas for future training. A district nurse monthly newsletter had been introduced in response to feedback from staff exit interviews around poor communication with staff.

Innovation, improvement and sustainability

- There were a number of service reviews taking place. We saw reports from the musculoskeletal physiotherapy service and falls service that identified changes to services, to benefit patients. The impact, cost and expected outcomes were reported and considered by senior management, with discussions with the clinical commissioning group where appropriate.
- The directorate were working with the CCG to review some standalone services provide by the district nurses, such as flu vaccines. It was proposed these services be provided by another provider to help address some issues of this services being unable to meet its current demand.
- A productivity review of the district using service was also taking place, activity was being reviewed by teams, to ensure consistency across the service and maximum productivity was being achieved.
- Assistant practitioners had received specific continence training. They had worked with patients and had achieved a cost saving through use of less continence pads and improved wellbeing for patients.
- The home oxygen service had developed a home oxygen risk assessment tool, as no national evidenced based tool was available. The team was working with the research department at the trust to develop an evidence base for this. Staff from the team told us the tool was being used by other home oxygen services nationally in the absence of a national tool. The tool enabled staff to quantify the level of risk, work with patients and their families to mitigate the risk or to provide evidence that the risk was too great to consider oxygen therapy in a patients' home.