

Solent NHS Trust

RC1

Community health services for adults

Quality Report

Highpoint Venue
Bursledon Road
Southampton
Hampshire
SO19 8BR
Tel: 023 8060 8900
Website: www.solent.nhs.uk

Date of inspection visit: 27 - 30 June 2016
Date of publication: 15/11/2016

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)
R1C03	Western Community Hospital		SO16 4XE
R1C34	Royal South Hants Hospital		SO14 0YG
R1C17	St Mary's Hospital		PO3 6AD
R1CF2	St James Hospital		PO4 8LD
R1CD1	Adelaide Health Centre		SO16 4XE







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

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

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	7
Our inspection team	7
Why we carried out this inspection	7
How we carried out this inspection	7
What people who use the provider say	8
Areas for improvement	9

Detailed findings from this inspection

The five questions we ask about core services and what we found	10
Action we have told the provider to take	41

Summary of findings

Overall summary

Overall rating for this core service **Good**

We found that the 'caring' in community services for adults was found to be 'good', 'good' for 'effective, responsive and well led' and 'requires improvement' for 'safe domains because:-

- The trust had many examples of responsive teams working collaboratively to meet their patients' needs. They provided care close to or within the patients' home environment, thus reducing hospital admissions. Staff used comprehensive holistic patient risk and care assessments, to identify and respond to risks including the safety, health and wellbeing of patients in the community within their care.
- The trust staff followed process and set procedures to report safety incidents and manage risks. The teams used a 'governance tracker' dashboard to monitor serious incidents, staffing information and patient feedback. Most staff had learning from incidents shared with them. There was a pro-active approach to following patient safeguarding procedures. The staff, however, did not understand or follow the full requirements of the Duty of Candour, and this was not carried out appropriately.
- Patient and their families received compassionate, focused care, which respected their privacy and dignity. They told us they were involved in planning their care and without exception, patients we spoke with praised staff for their kindness, caring and empathy. Most formal patient feedback was positive, although where there were complaints; clear action plans were in place.
- Community services for adults provided care based upon the latest national guidance from the National Institute for Health and Care Excellence (NICE). There was well-established multidisciplinary team (MDT) working across all the teams we visited. Staff had mandatory training and most had had appraisals and access to personal development.
- The trust had actively engaged staff in agreeing values to support the trust vision and strategy.
- The trust environments were generally clean with the exception of the Bitterne Health Centre, which had numerous cleanliness and environmental concerns some of which did not support safe patient care.

However

- The geographical differences in the location of services and in their commissioning and delivery meant that there were differences in the delivery of care across both areas, with some staff feeling there were also inequities in opportunities and learning.
- The teams described feeling quite separate across the two cities; staff described different working practices across Portsmouth and Southampton for example; the management of pressure ulcers affected patients, with Southampton's incident rates improving and Portsmouth's incident rates worsening.
- Community nursing teams particularly in Portsmouth had significant registered nurse vacancies that the trust told us had recently reduced to 19% from much higher. The safety of patients could be affected while they were waiting for visits and staff were concerned that their workload was too high to care for patients properly. We observed the frequent overflow of unmet visits to the following nursing shift.
- The trust staff did not always manage to update patient records in a way that kept patients safe. IT connectivity problems and pressures on staff time meant there were risks of delayed recording and a possibility for incomplete records. Bank nurses we spoke with did not have access to the electronic patient record system, and were dependent on access via substantive staff colleagues to record patient information.
- There were significant delays in the provision of wheelchairs and repair service through an external provider, which affected the safety and well-being of many patients receiving adult community services in different localities. We were told of vulnerable patients being kept in bed at home because of a lack of appropriate seating. There had been an increase in referrals to the psychology service for those patients waiting for wheelchairs due to their low mood and depression caused by the wait.

Summary of findings

- Some specialist services such as bladder and bowel were not achieving the 18 week referral to treatment targets pathway. Whilst the podiatry pathway had been changed in conjunction with the local commissioners, the service aimed to meet with individual patients to explain the circumstances and to offer support and signposting for onward treatment. However, some patients were still travelling to clinic appointments with expectations of potential surgery. They appeared unaware that surgery would be available from other providers. Therapist staffing shortages in some teams had also extended the waits for services for example, Speech and Language Therapy (SALT) and the community independence teams in Southampton.

Summary of findings

Background to the service

The trust provides a range of adult community services to support people in staying healthy, to help them manage their long-term conditions, to avoid hospital admission and support them at home following discharge from hospital.

Adult community services are provided across Portsmouth and Southampton at a wide range of community locations including hospitals, clinics and health centres. Services visited across the three localities in each city included:

- Community nursing, including a night nursing service
- Community matrons
- Rapid response teams which provided timely care and treatments to prevent hospital admission
- Single point of access, this was the hub for all patient referrals and appointment booking.
- Clinical nurse specialist services
- Community independence teams (Southampton)
- Rehabilitation and reablement team (Portsmouth)
- Podiatry and podiatric surgery
- Integrated rehabilitation services for long-term conditions, including pulmonary and cardiac
- Community neuro rehabilitation teams
- Community stroke rehabilitation team
- Early supported discharge and frailty intervention teams
- Clinical advisory team
- Pain service
- Speech and language therapy
- Tissue viability team

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Joyce Frederick

Inspection Manager/ Community: Moira Black

The team that inspected adult community healthcare services included CQC inspection managers, CQC inspectors, two experts by experience (carers of people

who had used community services) and a variety of specialists: community matrons, district nurses, consultant geriatrician, specialist community nurses, and specialist end of life care nurses. Community physiotherapists, community occupational therapists, speech and language therapist and a pharmacist were also part of the inspection team.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
 - Is it effective?
 - Is it caring?
 - Is it responsive to people's needs?
 - Is it well-led?
- Before visiting Solent Community NHS Trust, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.
- We carried out an announced visit on 27-30 June 2016. Before and during the visit we held focus groups with a

Summary of findings

range of staff who worked within the service, such as nurses, specialist nurses, managers and therapists. We talked with people who use services, observed how people were being cared for, and spoke with carers and family members.

We reviewed 31 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.

As part of the inspection, we spoke with 320 individual staff members, 52 patients, and 6 carers.

What people who use the provider say

We spoke with 52 patients as well as carers, relatives and loved ones covering all adult community services we visited over the 4 days of our inspection.

We spoke with patients in clinics, at rehabilitation classes, on home visits and on the telephone. We received positive feedback from everyone we spoke with. Patients and carers were pleased with the services they received and spoke in glowing terms of the care and kindness that staff gave them.

Patients and carers felt involved in their care, and told us they were encouraged to agree goals as part of their treatment plans. They felt the goals were specific to their personal needs and values.

The comments that we received from patients and carers showed how they valued the service being delivered to them, they said the staff 'were like friends' 'awesome' 'very supportive staff' and 'my care is brilliant' 'staff are absolutely caring and interested in me'.

The patients described how the staff considered them holistically, including assessing their carers for stress and including them in the rehabilitation goal setting. They provided many examples of how the staff had helped them with getting equipment or providing care and support to them and their family.

Information in many forms was available, including verbal, written, electronic information, and staff signposted them to appropriate resources.

Overall, we saw how the trust staff were extremely caring and patient focused, they treated the patient and their family to achieve the best possible personal outcomes and signposted them to support services where they were available.

Despite low staffing numbers in some teams, the patients were not made aware, and were consistently treated with respect, consideration and kindness.

The observation of virtual ward meetings and handovers in most localities included a robust clinician led medication review. There was appropriate discussion about efficacy, multi pharmacy and potential over prescribing.

The trust had created the stroke community rehabilitation team and the Snowdon at home team (for other neurological conditions), in line with national guidance for early supported discharge from the acute hospital. Of the patients received from the stroke ward (normally Southampton), 50% were discharged within 10 days and then supported by a six weeks therapy programme. There was a capacity of 20 patients, dependent upon clinical pressures. The teams were recently co-located with one manager to support the best use of resources for a responsive service. The Snowdon at home service for example, visited the patient up to five times per week

Pulmonary rehabilitation was an integrated service, planned and delivered in partnership with the local acute hospital. Venues across the community provided a range of classes; patient questionnaires provided feedback on patient preferences. There was a reciprocal arrangement with a neighbouring trust so those just outside the catchment area were able to access a class nearer to where they lived. Following extensive evidence of the positive benefits to patients, funding was obtained to deliver singing classes

Summary of findings

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

The trust **must** ensure:

- That there are sufficient numbers of suitably qualified staff in all community teams to ensure consistently safe and timely care is given as planned to meet patient's needs.
- Action is taken to reduce avoidable harm, specifically, the incidence of pressure ulcers.
- Patients are protected against the risks of unsafe or inappropriate care and treatment arising from incomplete patient records or an inability to access electronic patient records when required by staff, including bank staff.
- There is work with the external provider of wheelchairs to provide a more responsive and timely service and that this service is appropriately monitored to reduce risk to patients.
- Staff are aware and understand the full requirements of the duty of candour, which are correctly carried out.
- That all facilities used for patient care are provided with emergency alarms.

- That appropriate standards of cleanliness are maintained in all clinical environments to provide safe patient care.

The trust **should** ensure:

- Staff across both cities are encouraged to engage with other teams to ensure seamless service and full understanding of current changes.
- Leadership teams support staff to reduce identified inequality and reduce staff feelings of isolation or disconnection from the service.
- That a trust wide standard resuscitation equipment list is agreed across all clinical areas and staff are appropriately trained to use it.
- That there is clear communication to patients about any changes to the clinical services offered by the trust, and any changes to appointments previously issued.
- That clinical audits action plans are followed up and completed appropriately.

Solent NHS Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

By safe we mean that people are protected from abuse

We rated safe as requires improvement because:

- Patient records within the trust were not sufficiently well managed to keep patients safe. IT connectivity problems and pressures on staff time meant there were risks of delayed recording and a possibility for incomplete records.
- Most bank nurses did not have password access to electronic patient record systems, and were dependent on access via substantive staff colleagues to record patient information. This is against the principles of information governance regarding password protection and the Nursing and Midwifery code of practice (NMC) which requires registered nurses to 'attribute any entries you make in any paper or electronic records to yourself, ...take all steps to make sure that all records are kept securely'
- Although most staff knew how to report incidents on line, the lack of IT equipment or connectivity away from an office base caused delays in reporting.
- The different locality management of pressure ulcers affected patients, with Southampton's rates improving and Portsmouth's rates worsening
- There were significant registered nurse vacancies of 19% in community nursing teams particularly in Portsmouth (that had recently been much higher) and although bank and agency staff were requested, not all shifts were covered. This affected the safety of patients waiting for visits, and staff who were concerned that their workload was too high to care for patients properly.
- The environment and cleanliness at Bitterne Health Centre did not always support safe care.
- There was no standardised equipment list for resuscitation equipment across the services.
- The delays in wheelchair provision and repair service (through an external provider) affected the safety and well-being of many patients who received adult

Are services safe?

community services. Some patients had inappropriate seating, some vulnerable patients had to remain in bed, and there had been an increase in referrals to the psychology service due to the patients' low mood.

- Not all staff were aware of the process or were ordering and obtaining essential patient safety equipment, particularly out of hours and weekends.
- Not all staff we spoke to understood the full requirements of the duty of candour, including a written apology from the trust and the offer of a copy of the investigation report to the patient.

However

- Staff used trust wide systems to report and record safety incidents, near misses and allegations of abuse, and these were escalated and investigated appropriately. Staff were keen to share learning and practice changes that had occurred because of incidents.
- Staff used comprehensive holistic patient risk and care assessments, and most teams had broad MDT review, to identify and respond to risks to the safety, health and wellbeing of patients in the community within their care.
- Most staff were up to date with mandatory training and there was awareness and a pro-active approach to following safeguarding procedures.

Safety performance

- The trust monitored NHS safety thermometer data about the care provided by the community services for adults. The NHS safety thermometer was a monthly snapshot audit of progress in providing harm-free care for patients. The types of harm monitored included falls, new pressure ulcers, urinary tract infections and venous thromboembolism (blood clots). For the months of April, May and June 2016 the average percentage numbers of patients that received harm free care was between 94.2% and 97.7%, an overall average of 96.2%.
- There were 87 serious incidents reported 1 January 2015 to 31 December 2015, for patients in the community health services for adults, of which 73 were Grade 3 or Grade 4 pressure ulcers.
- Individual service lines within community services for adults had quality dashboards. These monitored safety information, such as healthcare associated infections, avoidable pressure ulcers acquired in the community, information governance breaches as well as information related to workforce and patient experience feedback.

Incident reporting, learning and improvement

- The trust had robust systems to report and record safety incidents, near misses and allegations of abuse.
- The senior leads of the service described themselves as high reporters of incidents; they told us they were keen to share incidents to provide learning across locality teams. They received approximately; 100-150 incidents every month via an electronic reporting tool. They reviewed the governance dashboard, which illustrated the progress of acting upon incidents. The dashboard kept governance oversight and review throughout the organisation.
- Staff we spoke with knew how to recognise and report incidents on the trusts electronic recording system. They reported incidents and were able to discuss them with their line managers. They gave us examples of a range of reportable incidents such as accidents, pressure ulcers, medication errors, slips, trips and falls. However, due to lack of equipment or IT connectivity issues, staff could not always access on-line reporting in the community but had to return to a hub office to do so; this could cause delays in reporting incidents.
- The quality and risk team reviewed all reports and identified any potential serious incidents, and called a 'strategy' meeting where the initial investigation and findings were discussed. They appointed trained investigators who investigated using root cause analysis and prepared a detailed report.
- Most teams were very keen to share examples of recent actions or learning across the service. For example, following the identification of a trend of incidents of bursting physiotherapy balls in different teams, neuro-rehabilitation services told us how they were purchased had changed across the trust. Staff in cardiac rehabilitation told us they had reviewed their clinical assessment processes and risk assessed exercise class venues after a patient had had an acute angina attack in a non-clinical environment. The tissue viability team tracked all Grade 2 pressure ulcers to ensure interventions had taken place appropriately following a recent serious incident. The community team told us that following a patient's death, staff used a new escalation plan, which alerted them of a patient's deterioration. Another incident had allowed teams to

Are services safe?

access emergency entry to a patient's home by accessing the central key holders. In addition, where patients with the same surname received the wrong letter, the team implemented a new process.

- Staff told us that there had been a large backlog of Grade 3 and 4 pressure ulcer strategy or investigation panels; mainly due to delays due to staffing gaps. However, "bank" investigators were appointed and collective reviews were held and reported to clear the backlog of panels and then to support timely investigation and learning from all pressure ulcers.
- Staff used regular staff meetings or newsletters to share learning and trends from incidents, this was confirmed by community nurses in Southampton localities who had attended meetings with other teams where actions from incidents or good practices had been shared. They told us that they felt confident to discuss or raise concerns. However, in contrast, although the Portsmouth community nursing team reported incidents, they felt that feedback was not always forthcoming about any resulting actions or changes.
- Staff we spoke with confirmed that the trust disseminated safety alerts via the new organisational wide IT system.
- The trust collated monthly data on expected and unexpected deaths and there were mortality and morbidity review meetings for unexpected deaths.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of their responsibilities to be open and honest following incidents that had caused moderate or severe harm to a patient. However, some staff told us that it was their understanding that the trust's usual practice was for informal verbal feedback with the patient. The discussions were recorded within the patient's records rather than any more formal written apology or copy of any investigations. Although, the trust policy stated that both verbal and written apologies should be given, according to some staff we spoke with, this rarely if ever happened in practice.

- The duty of candour was part of mandatory staff training; the trust newsletter also raised awareness. Monitoring of the compliance of duty of candour took place during any investigation of the serious incident (SIRI/HIRI) process by the risk team

Safeguarding

- Staff told us they had received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy. The staff numbers who had completed safeguarding training varied across the community services. For example, in April 2016, 70% of staff who worked in the service in Portsmouth had completed safeguarding adults training. In Southampton 84% were compliant. The lowest compliance in the specialist teams who worked in the community service was stoma care. The team had just over five whole time equivalents (WTE) within it, only 33.3%, or two WTE members had been trained. The trust target for safeguarding training was 75%.
- Some of the locality teams had local safeguarding leads that staff accessed for support, although not all staff we spoke with were aware of them.
- Safeguarding procedures were clearly in the clinics and the community nursing offices we inspected. Staff told us they raised safeguarding concerns online to inform the Solent safeguarding team and their manager; these were forwarded to the local authority for action. They told us they often took advice from adult social care colleagues on any concerns.
- Community teams confirmed they discussed any safeguarding concerns in handovers, to encourage staff to recognise and share concerns.

Medicines

- The trust had a medicines policy and a controlled drug policy that detailed specific arrangements for medication administration in people's homes.
- We saw that most teams used competency-based assessments, to support safe medication administration practice.
- There were six different medication audits in 2015, plus three missed dose audits but they were used for inpatients rather than community patients.

Are services safe?

- All community matrons in Southampton were independent prescribers, which meant they could respond to patients needs and prescribe appropriate medication in a timely way; they told us they received regular prescribing updates.
- The observation of virtual ward meetings and handovers in most localities included a robust clinician led medication review. There was appropriate discussion about efficacy, multi pharmacy and potential over prescribing.
- We looked at a medication store located in the urgent response team in Southampton, all the medications stocked were in date and stock rotation took place to ensure that stock did not go out of date. Out of hours, the two-team members on the shift checked any patient medication.
- The end of life team GP was available for any out of hour's medication prescriptions, preventing patients waiting. Two registered nurses were needed to check and set up a syringe driver (an electronic automated medication dispenser), but to prevent delay to the patient, we were told that a single registered nurse was allowed refill the syringe driver.
- We saw one medication administration chart dated 2010 that was being used for a regular insulin prescription. The community nursing team had not signed the administration chart to show the medication had been given to the patient, which was against the trust policy. The team noted the patient had consistently high blood sugars, which the nursing team had regularly recorded. However, there had been no escalation or recent review of the insulin dosage. We raised our concerns and requested the patient's nursing team to take immediate action.
- The home oxygen team in the Portsmouth locality had a caseload of approximately 300 patients, referred by community health or acute trust health care professionals. The team assessed new patients' oxygen needs at home and provided patients with long-term oxygen therapy and ambulatory oxygen equipment if required. They provided a follow up appointment if needed. The supplier of home oxygen was an external company that had given good service in the past. Every patient had an assessment for safety in the home and given a fire safety leaflet. The team did not supply oxygen if the fire assessment showed that home risks were too high.

Environment and equipment

- The trust obtained most of the equipment provided to patients at home from an external provider who was responsible for cleaning, servicing and delivering equipment to patients at home. Equipment decontamination and maintenance was the responsibility of the private contractor.
- The local acute trust decontaminated and maintained medical devices as they provided an outreach service into the community and into patients' homes.
- The clinical advisory team who oversaw the use of equipment assessed complex patients, then advised and trained staff on the correct use of equipment to keep patients safe.
- The tissue viability team had input into the equipment selection. They said their suppliers provided a 'good service'. There was a three-year contract in place, and while the initial six months had been difficult in accessing sufficient supplies of equipment, it was now quite robust. The team had found initially that staff ordered 'a lot' of dynamic mattresses inappropriately; therefore retraining was carried out to ensure their appropriate use.
- Staff told us they were able to order equipment electronically for patients when required. For example, they ordered mobility, daily living, and moving and handling equipment, clearly prioritised as either urgent or routine. Staff told us they did not usually experience delays with deliveries. There were small emergency stores that contained basic safety equipment accessed by community staff and staff working within ED teams. Staff told us that it was sometimes difficult to access equipment for West Hampshire patients. We were told that out of hours, staff did not normally order equipment even pressure relieving mattresses, but used overlays which are of limited value in the prevention of pressure ulcers. National Institution for Clinical Excellence (NICE) recommends the use of high-specification foam mattresses in the community with at least four hourly position changes.
- The equipment out of hour's service had on call drivers available every day of the year, from both the Portsmouth and Southampton bases. There was normally a same-day delivery service that included weekends for hoists and beds. However, not all staff we spoke with knew about the weekend service for equipment or the procedure for urgent ordering. One

Are services safe?

team highlighted a recent incident where the delivery drivers were found to be inaccessible (no phones) at the weekend when an urgent item was needed. Some community staff, out of hour's and bank staff were unable to order equipment, as they had no 'PIN number' to use. Most bank staff had no IT access. Some staff felt that equipment requests had to be 'signed off' by their managers and there were delays due to this system. They were unsure who signed orders in their absence. This uncertainty was seen on inspection when an elderly patient was waiting over a week for a bed and mattress and left vulnerable to pressure ulcers, we were told an incident form had been completed.

- The same company that provided patient equipment had been the provider of patient wheelchairs for the past two years. Almost every service we spoke with told us about the extremely long delays in accessing wheelchairs, some patients had waited for up to two years, which had affected their well being and outcomes. The teams stated that the use of inappropriate seating could prevent patients being sat in their best position, and may affect their safety. For example, being unable to drink and swallow without choking or to prevent the development of pressure sores. The company had also taken up to a month to complete wheelchair repairs. This meant that previously mobile and independent patients had been confined to their homes while they waited for repairs. Staff also told us of cases where different wheelchairs than the medically prescribed one were delivered to the patient, again the teams felt strongly that this was potentially a patient safety issue. The clinical advisory team had reportedly stated that only a wheelchair or specialist chair could be ordered per patient, not both, which staff felt could affect the patient's safety and well being (developing pressure sores) if the patient had to remain in a wheelchair at all times.
- The neuro rehabilitation service at their service line governance meeting discussed how they had responded to safety advice by replacing sensor mats after a year. Stock control had taken place by dating the new mats.
- Staff described having used 'talking mats' to assist in gaining an understanding of capacity of patients with communication difficulties.

- Some teams told us that they used charitable funds to access patient equipment for example; the cardiac rehabilitation team had ordered a diet map for patient education through this route.
- The location for the out of hour's urgent response team was changed, and this had caused staff to feel vulnerable and isolated at night. IT was only available to them via a virtual private network (VPN) through a commercial line or the council's IT system. These connections had proved unreliable and often IT was not accessible which affected patient care. There was a joint plan between Solent and Southampton City Council to address the issues. Staff told us of a referral that had got 'lost' during IT down time, which meant the patient could have been left at risk.
- Bitterne Health Centre (BHC) had become the new long-term conditions hub for all community specialist services (CSS) for 32 GPs across Southampton. The building was previously a 'walk-in centre'. All the patient weighing scales at BHC were three years out of date for recalibration; there was a risk that medications prescribed according to the patients weight may have been inaccurate. A bladder scanner and the portable suction were found to be out of date for safety testing, this was shared immediately with a member of staff.
- Due to environmental constraints at BHC, the resuscitation trolleys were kept behind doors with locked key pads. This location had been risk assessed and found to take staff at least three minutes to access emergency equipment. There were no emergency alarms in any of the consulting rooms.
- BHC staff told us that there was no standardisation of resuscitation trolleys or equipment within the trust, as the trust had no resuscitation officer. Staff accessed support from another local trust's resuscitation officer and accessed suitable equipment for BHC.
- BHC was the new CSS hub for long-term conditions and had multispecialty consultation rooms. two of the consultation rooms in use at BHC had no privacy screening for patients, despite having windows.

Quality of records

- We reviewed 31 care records across different teams in multiple locations. The quality of records varied with a combination of paper and electronic patient record keeping systems used. Patients' having home visits had paper records held in their homes. An electronic

Are services safe?

recording system was being introduced across all the community services. Some of the staff told us that repeated IT issues had made access to this system difficult.

- Community nursing records contained all appropriate risk assessments, screening tools, care plans, mental test scores, therapy outcome measures, falls histories, contact notes, and consent advice leaflets.
- The electronic patient record allowed for the link up of risk assessments, such as Waterlow (for assessing the degree of patient's risk of a pressure ulcer), MUST (a nutritional screening tool), the pressure ulcer risk tool, care plans and wound assessments. Teams adapted a standard care plan within the electronic care record to fit patients' needs.
- We witnessed the completion of residential care home records and then the records entered into the Solent electronic care record to ensure that records were updated and accessible to all staff that cared for the patient. The trust audited the patient care records regularly to ensure staff met and maintained standards. The inspection team reviewed patients records; they included initial assessments, goals and progress reports, discharge plans and letters. The 'Snowdon at home' team's care records illustrated appropriate assessments, goal setting, discharge plans and joint therapy visit outcomes. The frailty intervention team (FIT) based in ED within one of the local acute trust, reported that the team needed to change their paperwork often to capture both the acute trust's and its own key performance indicators (KPIs). The team were working with ED on a frailty pathway, to ensure that a contemporaneous record accompanied the patient. The patient records in use within the FIT team were complete, signed and dated, and stored securely in a locked drawer in the office. The team described how they had to duplicate patient records, both within ED paperwork and input the electronic patient record.
- The hydrotherapy service described how they accessed the electronic patient record poolside and felt positive that GPs were able to access their patient's progress notes.
- The trust had not issued all staff with laptops at the time of the inspection. The nurses had to update their patients' records at their desk base, which meant records might not be contemporaneous. There was a potential for missed safety risks as duplication of records in paper and electronically did not always take

place as some community nursing teams expressed confusion over duplicating records. Staff recognised the importance of keeping the information up to date on the system. However, staff told us that records, including incident records were usually completed in the office, at the end of a shift, or after days off. This was due to connectivity problems and the time taken to complete records online.

- Most bank nurses did not have access to electronic records, and used their working partners' access) to record patient details. This was against the principles of information governance relating to the sharing of passwords and the Nursing and Midwifery code of practice (NMC) which requires registered nurses to 'attribute any entries you make in any paper or electronic records to yourself, ...take all steps to make sure that all records are kept securely'.
- Throughout our inspection, we observed staff ensuring that whenever patient records were out of the office; they were secured in locked bags and patient confidentiality was maintained.

Cleanliness, infection control and hygiene

- Most staff had infection control training; the compliance rate varied from 66.7% to 90.3% the trust target for mandatory training overall of which infection control was part was 85%.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinic and home environments. We observed a high degree of compliance with hand hygiene, isolation procedures and the correct use by community nurses of personal protective equipment (PPE), such as gloves and aprons. Staff adhered to the trust 'bare below the elbows' policy in clinics and home environments.
- Hand washing facilities and alcohol hand gel were available throughout the clinic areas. Staff we observed followed good infection prevention and control procedures when working in the community. However, we saw one community nurse with poor hand hygiene when administering insulin to a patient with an insulin pen.
- Adelaide Health Centre was the new location for podiatry and other clinics within Southampton, it was a clean and well-maintained facility and both the staff and patients told us how much they appreciated the move to the new environment.

Are services safe?

- Most areas were visibly clean. However, there were numerous environmental issues seen at Bitterne Health Centre (BHC). There was surface dust on computers and portable suction equipment, the privacy curtains were not clean and six months out of date for changing. There were dirty carpets on the floor, very old and torn hessian covered notice boards and exposed pipe lagging in clinical rooms, which were impossible to clean effectively. The cleaning checklist in the sluice had never been completed; and a 'plant room' store was being used as staff changing room. We informed a member of staff immediately of all the issues seen.
- The community teams used the 'stratification of risks document', which assessed patients' criteria and guided their placement to a virtual ward or urgent response team.
- The virtual wards used observation charts, however, they did not use the national early warning score (NEWS), which is based upon regular levels of patient's observations. If the patient deteriorated clinically, they were referred back to the urgent response team who used the NEWS to recognise and escalate any deterioration. We saw one patient who had a GP requested due to deteriorating symptoms, but the request declined. The nursing team had raised this appropriately as an incident.

Mandatory training

- Mandatory training covered a range of topics, which included fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, communication, consent, complaints handling and information governance training.
- Staff received an electronic reminder when their training was due. Team leads received notification when mandatory training was due for their team members.
- The trust compliance target was 85% and trust data showed the compliance with mandatory training was generally high across the community health services although there was some variation.
- Staff accessed mandatory training on line, only desktop computers could be used for on-line training; not trust laptops. The staff stated that it was often difficult to find a computer to work on and the office environment was noisy for learning.
- Many staff we spoke with preferred face-to-face training and some felt that on line training was not ideal for some types of training. For example; staff felt the on line dementia training was suitable for a refresher. However, they felt there was insufficient information for those staff new to the subject.
- Any patient assessed at risk from a pressure ulcer had an 'at risk' care plan. If they declined advice, this was documented in their records. The tissue viability team had brought in a 'second eyes' system for grading pressure ulcers. However, there were two different systems used across the localities. In Portsmouth, two members of the team visually inspected the ulcer while in Southampton the ulcer was photographed using a secure phone; the team told us how the images were kept secure. The tissue viability team then graded the ulcer from the photograph and prescribed care. Portsmouth locality's numbers of pressure ulcers had risen whereas Southampton had reduced.
- The inspection team attended handover meetings at community nursing teams, urgent response teams, virtual ward and independence team rounds and a neuro rehab team handover. We observed patients' health and well-being discussed in detail with risks identified in most cases, with changes being handed over to the next team.
- The virtual ward or independence team handovers were detailed and thorough. We observed do not attempt resuscitation (DNAR) discussed and anticipatory care plans were in place for the ambulance service. There was a clear working link to the urgent response teams when patients needed greater clinical support.
- The urgent response out of hour's team had a physical handover in the evening but did not verbally handover to the morning team. They used a diary instead; this meant potentially there was no opportunity to clarify individual care.
- 'Snowdon at home', therapy handovers were thorough and covered a full understanding of their patients risks and concerns and plans for interventions around them.

Assessing and responding to patient risk

- We observed comprehensive holistic patient risk and care assessments during home visits with nursing staff who responded to individual patient risks. There were daily discussions of complex patients and their comprehensive risk assessments, any changing risks, any end of life issues including falls risk assessments.

Are services safe?

- Some teams used the situational background assessment recommendation (SBAR) tool to make sure that all relevant points were covered in discussions about individual patients.
- The cardiac rehabilitation team described, how prior to each class they ensured each venue had a defibrillator, oxygen and an emergency bag to respond to any emergencies. Although no patient had had a cardiac arrest, they were occasionally unwell and the team previously had to call the emergency services to support the patient.

Staffing levels and caseload

- The trust reported that the percentage of total vacancies for community services as of 30 April 2016 was 11.2%. The total number vacancies for full time equivalent registered nurses across all the community teams was 44.76 whole time equivalents (WTE) and for the health care support workers 11.69 (WTE). The trust localities varied for community nurse vacancies.
- Insufficient staffing was a particular concern for the Portsmouth community nursing team. The trust told us vacancies had now reduced to 19% but they had previously been much higher. Staff told us this was a result of an unpopular shift change. The high vacancy rate affected nurses being able to attend patient visits on time, resulting in frequently rescheduled visits. Some staff members described cancelling and rearranging a planned patient's visit four times due to staff shortages.
- The Portsmouth nursing team described low staffing and high workload, which led to incomplete non-contemporaneous patient records, having increased medication errors; but not having time to raise incident forms and potentially missed pressure ulcers.
- Some staff described feeling stretched, overworked and under pressure at times, and many staff told us they had been frequently working over their contracted hours to deliver patient care but had not logged the hours, so there was no evidence to prove how many. Some told us of difficulties in finding time for their mandatory training within their working hours.
- The trust told us that with the new nurse starters, who commenced the week after the inspection, the Portsmouth community nurse vacancies would be down to 13%. The senior team were aiming for 3% vacancies overall by September 2016. Southampton community nursing team, were at 3.6 % vacancies overall, with the central team the highest at over 15% vacancies.
- The trust used bank and agency staff where possible to support the limited resources, but staff told us that bank or agency nurses did not always fully cover the vacancies or sicknesses. The trust provided data that showed that as of April 2016, bank or agency nurses had not filled approximately 6.5 % of vacant shifts to cover staff sickness, vacancies or absence.
- When the trust used Solent bank staff, there was a checklist for staff to check competencies for the role. This was not available for checking agency staff. Staff told us that temporary staff were not able to work the 'whole role' as trust policy stated that permanent trust staff had to complete many parts of the role. They felt that many staff were too anxious to raise their concerns. Many teams reported having to 'hold' vacant posts by the trust, which had only recently been advertised and allowed to recruit. The trust provided evidence to show that since April 2016 recruitment of posts had been taking place.
- A 'rating scale' was in use in Portsmouth to assess daily capacity and capability of the community teams. Managers received it each morning but there was no further opportunity for staff to update the capacity, so they felt the management team made decisions based on that morning's data, which may have changed during the day and could leave areas at risk. The staff gave an example of how following their submission that day a staff member was moved to support another locality however they then received additional patients from another locality which affected their capacity .
- The trust had undertaken a skill mix review in Portsmouth and as a result employed more health care support workers, with a robust induction programme to support them. The senior management team told us that the Southampton nursing teams had supported Portsmouth's nursing teams by teaching and up-skilling existing staff with key skills. A recruitment and retention premium had been offered to Portsmouth community nurses to help recruit to the significant gaps. Community independence and rehabilitation teams had regular caseload reviews because of the staffing pressures.
- Southampton community nursing teams were piloting an escalation and capacity tool to mitigate the impact of

Are services safe?

- staffing shortages and escalate concerns to senior managers. This tool was used to plan demand and capacity on a daily basis and had different contingency actions based on escalation rating of green, amber or black. Southampton team's told us they received 30% over plan more patients every day. They used bank or agency staff wherever possible and trust staff worked flexibly across teams as needed.
- The urgent response out of hour's team covered patients within Southampton city, the planned staffing was 1xRN + 1xHCSW who always worked together due to the out of hour's risks to their personal safety. The Portsmouth twilight nursing team linked between the day and night shift. They stated they covered many unachieved visits of patients from the day shift, which often meant taking phone calls from patients who were still expecting visits, which in turn took up their time answering.
 - Snowdon at home responded to vacancies by temporarily reducing their service to mainly working from 8am to 5pm (previously from 8am to 8pm). They had recruited a Band 4 therapy assistant, which was a new role, to be competent in initiating and altering care plans. The team were devising clinical competencies for the new post. Staff informed us that with the recruitment they planned to return to the previous core hours by November 2016.
 - There were therapist vacancies with agency therapy used across the trust for maternity leave cover. For example, the central independence teams had employed locum physiotherapists to manage their workload as the longest patient waiting was 11 weeks, with 150 cases awaiting prioritisation and allocation. In the west locality, they had 50% physiotherapist vacancies and 25% Band 4 vacancies due to sickness. Agency physiotherapists were used where possible and there was daily prioritisation of patients to mitigate risks. The neuro rehabilitation team reported that recruitment of physiotherapists had improved since rotational posts were set up with the acute trust.
 - Speech and language therapy (SALT) reported multiple challenges in their staffing establishment, resulting in between six to thirteen week wait for patients following their initial referral prioritisation within two days. They had recently decided to run 'open' recruitment to generate potential interest in the service.

- Podiatry Southampton had reported difficulties in recruiting in the past, as more practitioners moved into private practice. They had recently moved to the first floor Adelaide House so felt that they may be more attractive to applicants in the more attractive accessible location.
- Staff who worked in the single point of access (SPA) told us they found the number of 'callers waiting' display on their screen stressful.

Managing anticipated risks

- Staff told us there was no resuscitation officer employed in the trust at the time of the inspection. Bitterne Health Centre (BHC) staff described repeatedly raising concerns regarding there being no resuscitation equipment in the centre since October 2015 when the 'walk-in' centre closed. The team within BHC escalated the issue to the risk register in January 2016, then to the governance meeting in March 2016 and finally to the chief nurse in April 2016. In June 2016, the trust purchased resuscitation equipment and it was in place on 22 June 2016 although the staff still needed training when we inspected.
- The single point of access team reported that call handlers risk assessed calls using templates, but also used a variable approach. For example, they accessed professional advice when needed and police support for dealing with frequent aggressive callers.
- There was an emergency backup plan for the single point of access in case of bad weather. Laptops were planned to be used at different locations. If there was no power, there was no back-up generator on site, so the 111 NHS help number would be used as a contact to call.
- We saw evidence of the IT business continuity plan being used at BHC when we visited, the phones linked to patient bookings were down and patients were being informed of the ongoing issues.

Major incident awareness and training (only include at core service level if variation or specific concerns)

- There were policies and procedures in place for dealing with major incidents. The trust held a routine practice of a virtual major incident procedure to practice staff responses in Southampton, a few months before our inspection.

Are services effective?

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

Summary

We rated effective as good because:

- Care was delivered that took account of national guidance such as the National Institute for Clinical Excellence (NICE) guidelines. Some teams signposted their patient groups to relevant national guidance. There were links with universities in some services, which maintained an up to date awareness of clinical treatments and outcomes. The teams across a wide range of services were actively participating in national audits and some local audits, which showed positive outcomes for patients.
- Patients had their pain assessed and monitored depending on their needs. There were processes for obtaining pain relief for patients out of hours. Patients had their nutrition needs assessed and action plans with appropriate referrals to health care providers made.
- Most staff had received an annual appraisal and had opportunities for their personal development as a result. Staff we spoke with told us of numerous examples of training and development that staff had accessed. Some training had been on hold previously, however this was no longer the case.
- The trust had provided supervision, in various forms for most groups of staff with the exception of some small specialist teams.
- There were many examples of integrated multidisciplinary teams working well together particularly for patients with long-term chronic conditions. These often included team members from other organisations such as the local acute trusts, the local authority and a neighbouring community trust. The teams worked well together for the benefit of the patients.
- Throughout the inspection, we observed that the patients were consented appropriately and correctly, staff understood their roles and responsibilities regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

However

- There were local audits that had action plans, but no evidence of these being followed to completion.

Evidence based care and treatment

- Care was being delivered that took account of national guidance, such as National Institute for Clinical Excellence (NICE) guidelines, and were aware of recent changes in guidance. We witnessed staff talking to patients about the latest guidance and signposting them to information.
- Patients followed rehabilitation pathways, for example pulmonary, neurological, stroke and orthopaedic rehabilitation. Access to specialist advice was available when needed.
- Community staff in rehab and independence teams agreed goals and care pathways with patients and relatives at the start of treatment programmes, and regularly monitored and reviewed them.
- The neuro rehabilitation team told us they followed guidance from a range of charity organisations such as the motor neurone disease association, multiple sclerosis society, Parkinson's disease. They told us there were plans for lead roles for different conditions and development of pathways in line with latest NICE guidance and plans for a NICE guidelines and protocols group.
- We spoke with specialist teams across the trust including cardiac rehabilitation, diabetes, neuro rehabilitation, bladder and bowel, congestive obstructive pulmonary disease (COPD), speech and language therapy (SALT), tissue viability, stroke and early supported discharge services. These teams used best practice and NICE guidance to inform the care and services offered. For example, the COPD service supported patients with community singing groups for them to achieve the best possible quality of life. The COPD service was fully compliant with NICE guidelines, and used their recommendations for the specifications of any patient activities.
- The multiple sclerosis community focus group also observed NICE guidelines, this included aerobic

Are services effective?

exercise, cognitive behavioural therapy, and exercise referral for self-management; patients were also signposted to the patient friendly information on the NICE website.

- The neuro gym service provided a range of specialised sessions to support patient rehabilitation as well as maintenance of movement, based on latest evidence. The service undertook action research one example, was measuring a patient's arm recovery following the recovery programme.
- The bowel and bladder service incorporated evidence based guidance into their practice; they used NICE and clinically –specific national guidelines. The trust had appointed a trust wide falls lead, but we were told that the post holder had been moved to cover a vacant management post. The falls lead post had been left vacant and on hold. However, the falls assessment tool and pathway was based on NICE guidance. There were regular audits of falls assessments in community independence and rehab teams and feedback to staff on improvements in completion of the assessment. Local policies were in line with national guidelines and staff we spoke with. Patient records we reviewed showed appropriate risk assessments and care plans. The tissue viability team had links with the Tissue Viability Society and had training ongoing for a practitioner undergoing a doctorate in tissue viability via Birmingham University. The team were auditing the use of a new assessment tool and pathway for pressure ulcers, although the process varied across teams.
- The Southampton diabetes team was well established. Staff told us that following the National Diabetic Service recommendations to move diabetic care into the local GP domain, the diabetic clinical nurse specialists (CNS) had changed. There was a clinical research project, investigating carer-strain particularly in relation to diabetes. The diabetic CNS team provided group education to GP practices and intensive training to Type 1 diabetic patients, and checked their knowledge annually. Carbohydrate counting and meters were available to help patients adjust insulin in relation to their carbohydrate intake.
- Staff told us of good links with the local university on research evidence, for example the best footwear for stroke patients.

- The community stroke rehabilitation team were part of the Wessex stroke clinical forum which reviewed best practice in stroke care and undertook six monthly reviews

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

- We observed that community nurses assessed patients' pain, and requests for any reviews were promptly made to GPs, to enable prescription changes on the same day, avoiding the patient remaining in pain.
- We heard pain management being discussed, at MDT handovers in the virtual wards; aiming to reduce pain that could be limiting the patient's mobility and mood.
- The urgent response team used NEWS observation charts, which integrated pain scores.
- The trust pain team, accepted referrals for patients with long term and intractable pain issues, and were available for advice and support for individual patients. The multi-disciplinary pain team used pain management programmes including the 'acceptance and commitment therapy model', developed as best practice nationally. The pain team gave effectiveness questionnaires to the patients before and after the programme, and at six month follow up
- We observed the older peoples' support team based in the acute ED managed patient's pain assessments effectively.

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

- Patients' nutrition and hydration status was accurately assessed using the 'Malnutrition Universal Screening Tool' (MUST) by the community teams and recorded in most of the patients care plans which were examined. For those patients identified as nutritionally at risk, there was usually an action plan within the records. Community dietitians were available for at risk patients and responded to urgent and routine needs of patients.
- The speech and language team assessed and supported patients with swallowing difficulties.
- The urgent response team used an intentional rounding tool for patient's daily checks on nutrition and fluids, they reported any issues, and then took advice on any actions.

Are services effective?

- We saw the older peoples' support team based in the acute ED, focussed on ensuring patients had adequate food and fluid intake in order to avoid potential admissions.

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

- There was no evidence of telemedicine or remote patient monitoring shared with us on inspection.
- The trust was in the process of moving to an electronic patient record. Thus, currently the IT system did not fully support the clinical teams and their activities.
- The Snowdon at Home team reported having used the electronic patient record for some years and their staff used this confidently.

Patient outcomes

- The services had participated in all national audits for which they were eligible. These included the British Heart Foundation National Cardiac Rehabilitation, Chronic Obstructive Pulmonary Disease National Audit, English National Memory Clinics, National Diabetes, Sentinel Stroke National Audit Programme (SSNAP). The bladder and bowel service used the national outcome tools, with the ICIQ test monitoring its patient's outcomes.
- The trust had taken part in 80 local internal audits during 2015, of which nine were specific to community health services; these included an audit of patient falls assessments and leg ulcer care.
- Intermediate care and rehabilitation services participated in the National Intermediate Care Audit, published in December 2015; which gave the trust benchmarked data on their services against other national providers. For example, the trust's response from referral to assessment in the rapid response team was 4.8 hours against the national average of 3.7 hours. There were other areas in the report where the trust had performed better than the national average, such as patients returning to their own home, where it scored 71% against the national average of 67%.
- Staff teams reported better working relationships for staff and potentially better outcomes for patients following the new integrated hub for long-term conditions at Bitterne Health Centre (BHC) was set up. All long-term condition services were co-located at BHC and managed together.

- The falls assessment audit looked at staff completing records based on NICE Clinical Guideline 161. The audit team reviewed forty-eight records and found 100% of patients had a falls history recorded but only 52% of patients' medication reviewed. However, important elements such as continence, footwear, lower limb strength and walking and balance all scored higher. There was an action plan for improvements but it was not yet complete.
- The leg ulcer audit showed that against seven criteria in a sample group of 97 patients, 73% received appropriate care. An action plan for improvements was in place but it was not yet complete.
- Staff told us about clinically driven local audits, which aimed to improve practice and patient care. For example, patients cared for by the urgent response team had daily intentional rounding carried out, and since its introduction 12-18 months ago, staff told us that an audit showed that the incidence of pressure ulcers had reduced. The team was also auditing care plans and the use of MUST scores to maintain record keeping standards.
- There was a range of audits in Chronic Obstructive Pulmonary Disease (COPD). They included the Collaboration of Leaders in Health Research, COPD British Lung Foundation that was auditing patient outcomes in relation to singing exercises and the Gold Global Initiative specifically for obstructive lung disease, which was a breathlessness intervention audit.
- The community independence team used patient feedback and 'global impression of change' and therapy outcome measures for individuals, to measure the effectiveness of the programmes for each individual patient. Community independence and community rehabilitation teams both gave examples of positive outcomes for patients who were disengaged at the start of their programme but who had progressed to accessing community exercise classes and gyms by the end. Therapy and rehabilitation services involved the neuro gym patients agreeing goals in advance with the therapist.
- Cardiac rehabilitation services participated in relevant national audits and research. Staff told us that inputting data to the National Cardiac Rehab Audit had been challenging when administrative support left, but a new solution using the research team was agreed.
- We observed a community matron's visit to a patient, which involved all aspects of care. The patient received

Are services effective?

pain relief; medications including insulin and emotional support within the one visit. This patient had been supported in their own home for the past six to seven months with admission- avoidance taking place approximately monthly, with visits reduced from bi weekly to once weekly.

Competent staff

- We were told that new staff were given both a trust and local induction, some of which was electronic via the electronic staff record (ESR) system; staff confirmed this and said they felt well supported when they first started in the organisation.
- Trust managers told us they prioritised staff appraisal. Most staff told us they received regular annual appraisals. As of February 2016, 91.3% of staff within adult community teams had completed their appraisal. There were exceptions where some small teams had had no appraisals, for example, the out of hour's twilight service in Portsmouth.
- Staff told us a yearly training needs analysis across all teams was completed; the annual appraisal process in which staff would identify and agree personal development plans with their line managers informed this process. Learning beyond registration funding was available on application, but staff told us they thought the amount of money available had reduced. Staff were encouraged to feedback learning from any training at team meetings
- Staff had access to specific training to ensure they were able to meet the needs of their patients and their professional objectives. For example, cardiac rehabilitation nurses needed to have two days training in order to run the heart failure exercise course. Some staff such as the specialist nursing teams had opportunities to attend external conferences and other courses. Others, specifically some of the community nursing teams, reported finding time and a location to do their mandatory training was difficult. However, three Band 6 nurses were undertaking the district nursing course this year.
- The trust was supportive of higher-level study, with funding obtained for a masters in clinical research, which was a shared programme of work and study. There was also support to access specific masters training in podiatric surgery; however, staff shared concerns over its potential future use, with podiatric surgery pathways closed within the trust recently.
- Staff in community independence and rehabilitation teams had access to regular appraisal, clinical supervision and training. Staff told us they had been able to attend relevant conferences and forums as well as their in service training. Support workers in the integrated team, had been trained in additional skills to support their patients, for example, venepuncture. Some Band 4 staff were following a health and social care foundation degree programme.
- Administration staff told us for the past two years they had no training and only essential training was allowed for clinical staff, this restriction had now been lifted. E learning was provided, but some staff found it more difficult than face-to-face training.
- The clinical nurse specialist (CNS) teams provided education for clinical teams, the cardiac nurses held 'How to take a good ECG' and ECG interpretation twice a year, the tissue viability team provided training for Band 3 and above with competencies to support their development. We witnessed community staff illustrating their level of competency in their care of leg ulcer patients. They showed appropriate dressing selection and an understanding of the rationale behind the selection. The tissue viability team had planned to host a combined annual training day in collaboration with bladder and bowel and the dieticians' team. The diabetic team had a programme of education for the community teams to access, however attendance was not always good, so the training was open to nursing and residential homes for a fee, and any proceeds used within the service.
- Doppler assessments guided the care planning of patients with leg ulcers seen by the tissue viability team in Southampton. Community nurses monitored the progress of healing leg ulcers, by skin mapping and photographing ulcers regularly to ensure these were treated appropriately.
- The clinical advisory team included occupational therapists and nurses who were experts in posture assessment and pressure ulcer prevention. There were also 20 posture assessors in each city to support care planning and training in correct posture and positioning of patients with long-term conditions and complex needs. The clinical advisory team supported care planning and provided training for staff and carers on equipment and its use with individual patients.
- Supervision was taking place across the trust in both informal and formal formats; staff described regular

Are services effective?

meetings for supervision, of peer groups where similar grades and levels of experience were able to discuss issues confidentially. The CNS teams all reported the new hub at BHC provided informal peer support to other colleagues covering different services thus increasing their knowledge. Some staff also had one to one supervision. However, the frailty intervention team based in a local ED had no access to supervision, staff told us that it had not happened for the past 18 months. 'Management' supervision took place monthly to review service outcomes and key performance indicators.

- The community nursing team reported a 'Better Care Project' which was a monthly complex care meeting with the GP and other CNS that encouraged supportive reflective practice. There had also been tissue viability and male catheterisation training re-instigated in last six months to support the new staff in Portsmouth.
- All community matrons in Southampton were independent prescribers, and reported receiving updates relating to their competence regularly.
- Snowdon at Home rotated therapists yearly between Snowdon Ward and the community stroke team, the team expressed great job satisfaction working in Snowdon at Home and described a specific induction programme for new staff, which included the deprivation of liberty, safeguarding and 'do not attempt resuscitation' information.
- Community neurological rehabilitation teams held bi-monthly journal clubs to review learn and develop practice from relevant articles. Staff told us debates covered goal setting for patients with complex needs where it was difficult to measure effectiveness of services.
- Community teams had a mandatory mental capacity act and deprivation of liberty training; however, there were no known dementia link nurses or champions within the team spoken to. Although the trust told us that Southampton commissioned and provided admiral nurses to support patients living with dementia.
- Staff told us that they had received training in cardiopulmonary resuscitation (CPR) and were aware of procedures for getting assistance in an emergency. This trust data showed that 36 out of 43 teams in the community team for adult services had achieved over 90% compliance for resuscitation training. BHC staff were having additional specific defibrillator training arranged as previously only the cardiac and COPD clinical teams were trained.

Multi-disciplinary working and coordinated care pathways

- Many teams, including community recovery and rehabilitation, community neuro rehabilitation, early supported discharge and community independence teams were multi-disciplinary from a range of disciplines, medical, nursing, therapies and psychology. Staff worked closely with professionals inside and outside the teams, to support the patients. There were regular multidisciplinary (MDT) meetings and virtual ward meetings, including social care, which identified best options for holistic care and treatment, particularly for patients with complex needs.
- Virtual wards, for patient with complex needs in the community, had been in place across all localities in Southampton and Portsmouth for the past five years, and supported by two consultants.
- There was a MDT meeting of district nursing services for one locality of the three in Southampton every day, where the team was co-located. However, we observed the east locality meeting to be a more limited discussion relating to patients, goals and plans of care. No electronic records were made.
- The community independence teams recently co-located with adult social care staff and gave many examples of more effective care due to joint working. For example, joint assessment visits and access to different IT systems. The weekly meeting provided an opportunity for case education to take place.
- Staff in community independence teams felt they would benefit from closer links with GPs, although we heard of some therapists and community nurses attending GP cluster meetings, which had resulted in increased referrals to the rehabilitation team and admission avoidance.
- The clinical advisory team took an MDT approach to assessing for correct equipment for sleeping, sitting and moving and handling.
- The recent co-location of clinical nurse specialists in long-term conditions, to Bitterne Health Centre (BHC), provided opportunity for interaction and cross working; it was felt there was now a platform for all different long-term services. Specialist nurses worked closely with GPs, colleagues in the acute trust, the third sector, and other community services to support patients along their clinical pathway.

Are services effective?

- There was strong multi-disciplinary working, including with acute hospital consultants, in the assessment of patients and delivery of the integrated pulmonary rehabilitation service in Southampton. The COPD team supported GPs managing complex breathless patients, a home exercise programme, and the acute trust had a 'hot clinic' to avoid patients admittance to hospital. There was a community respiratory integrated service, (CRIS) which covered Basingstoke, Petersfield, Portsmouth and Fareham. It had a pulmonary rehabilitation team group for up to 39 patients and managed the home oxygen service. They visited the patient's home after an initial four weeks at home; a weekly MDT meeting also provided training to the doctors and they issued process flow charts to the local acute trust.
 - Diabetic CNS teams supported the community nursing teams for advice and support and by undertaking educational home visits to plan the care of complex patients, which were then followed by the community nursing teams. We witnessed a diabetic MDT, which was a patient centred discussion around services that patients needed, the CNS, nutritionist and a clinician were involved. The team discussed and agreed care plans for severe symptom control in individual patients.
 - The tissue viability service liaised with palliative care, rapid response team, urgent response, community matrons, diabetes and podiatry. There was a shared formulary with local hospitals to enable patient's continuity of care. A discussion took place with the acute trust and district nurse team if the patient had a large wound or the patient had complex care needs. They also linked into the spinal injury centre and plastic surgery team.
 - Snowdon at home had a fully structured MDT meeting, where staff considered all communication and translation issues, all aspects of physical, emotional and social needs of both carer and patient. The early supported stroke discharge team plus therapy leaders and assistants, nurses, psychologist and SALT attended this.
- accepted patients direct from the acute hospital, staff then referred on to the community neurological rehabilitation team or community independence team. The pulmonary rehabilitation team referred patients to maintenance classes once they had completed the intensive programme.
- The trust used single point of access (SPA) arrangements to screen referrals, for example stoma care into the service and to streamline the process. The SPA received patient referrals and reviewed them against specific criteria, and forwarded on to appropriate services. Staff told us that they also received referrals from community teams, from GPs, other healthcare professionals and self-referrals from patients themselves.
 - The urgent response team in Southampton had recently merged with the rehabilitation team 'reablement' and were now co-located and interprofessional, which included adult social care (ASC). The patient's initial visits were attended by whichever professional was booked for the first assessment visit, in other words not profession specific. This meant that the team could plan and start appropriate services immediately for the patient and prevented any delays.
 - The virtual wards, part of the community independence team, were linked into the urgent response team; there were plans for more integration. Virtual wards and integrated care teams in Southampton had close links into the discharge facilitators in the local acute trusts that ensured a seamless transition of care for the patients.
 - The neuro rehabilitation services included a transition service for patients aged 14 -25 years, to support young people moving into the community services.
 - Early supported stroke discharge (ESSD) team worked closely with the acute stroke team. Medical cover was provided by the GP initially, with any driving assessments organised by OT if and when required, and easy access to other services.
 - Snowdon at Home (Southampton), was available for six weeks therapy services for general/ neuro rehabilitation patients working closely with ESSD, and provided an in-reach service to the acute hospital to identify suitable patients. We observed detailed MDT discussion around goals and achievement's, and discharge date goals.
 - The trusts FIT team were based in a local acute trust's ED, they screened ED patients for frailty. Patients had an initial assessment, were then medically assessed and

Referral, transfer, discharge and transition

- There were a range of services and teams with clear referral criteria, designed to meet the needs of patients along care pathways. There was evidence of teams referring patients appropriately to services that best met their needs. For example, the community stroke team

Are services effective?

supported to go home or to a community step down bed. Patients over 70 yrs and those 65 yrs+ who came from a residential home, were given priority. Therapists were being included within the team to help with appropriate equipment assessment.

- Trust staff told us that the workflows in the community nursing teams in Portsmouth were at times ineffective. Some community nursing teams reported confusion on the overlap of visits with the community matrons. They stated it was not a clear pathway when the patients were discharged to community matron as this did not provide seven-day services. Staff felt that patients may be confused who to call at weekends which may result in a visit to ED or even an admission.

Access to information

- Staff access to IT systems was variable. Staff told us the IT system worked well at base locations, but there was limited access out in the community. Specialist nurses were unable to access the acute hospital or adult social care (ASC) records. Community reablement and independence teams were able to access ASC records via social care colleagues in the teams and office bases. The limitations of the IT systems had affected the effectiveness and performance data of all teams. For example, the tissue viability team who provided letters to GPs during patients' treatment and following their discharge used the Solent system. However, some GP based staff could not access the Solent electronic patient record, as it was unavailable in surgeries.
- Some of the virtual wards who had recently been co-located were able to access many systems back at their desk base, for example, third sector agencies such as Age UK on discharge and the community navigator resource.
- The speech and language therapy team told us that the electronic patient record greatly assisted their triage of patient referrals, as they viewed the waiting lists more easily.

- All team members of Portsmouth rehabilitation and reablement team (PRRT) expressed concern over the poor 'internal communications' which were described as 'not responsive'.

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

- We observed staff explaining procedures, giving patients opportunities to ask questions and seeking consent before providing care or treatment appropriately. For example, the urgent response team gained formal consent at the patient's first assessment and recorded it. The team sought verbal consent prior to each intervention.
- The community nursing team at all initial visits gained the patients dated signature to consent to share information. They contributed to information gathering in any Best Interests and Deprivation of Liberty meetings; usually a GP or mental health team would lead. We were told of a recent best interests meeting which resulted in a patient being referred into the older persons mental health team
- The Mental Capacity Act (2005) was part of mandatory training but the uptake was highly variable across teams. Staff had good understanding of the Mental Capacity Act (2005), and virtual ward meetings and MDT meetings regularly discussed patient capacity assessments and considered patients Best Interests. Community teams regularly faced issues of patient safety at home and the patient's capacity to make decisions. Staff described decisions regarding feeding tubes and said that the protocol included a capacity question. The trust provided guidance and templates for staff on 'big decisions' for patients on the intranet.

Are services caring?

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

Summary

We rated caring as good because:

- Across all teams, we witnessed all staff completely focused on doing their very best for their patients and their families despite continued staffing challenges.
 - The patients were consistently cared for holistically, including their spiritual and emotional support. The carers and significant others were included in this approach, with assessments to gauge their level of strain while they were caring for their loved one.
 - We observed that staff used a respectful, compassionate and kind approach; many patients gave positive feedback about the care they had received and the manner and approach of the staff.
 - Staff actively observed their patients privacy and dignity, ensuring that they referred back to them for their individual choices.
 - There was clear commitment to the importance of ensuring patient understanding and involvement in long-term treatment programmes, as positive engagement led to better outcomes and a higher likelihood of longer-term improvements for patients.
 - Patients and relatives we spoke with confirmed that they felt involved in their care. Patients told us the staff had explained their treatment options to them, and they were fully aware of their care plans.
 - The response rate to the Friends and Family test over the past 6 months were below the English national average at 2.2% responses instead of 3.4%, although of those who responded the percentage of patients that would recommend Solent for care was 96% and above the English national average which was 95%.
- compassion, dignity and respect. We observed that staff communicated with patients in a respectful way in all situations. Staff maintained patient confidentiality when attending to their care needs.
- We observed clinic staff preserved patient privacy and dignity, and highlighted to the patient the locked door and the pulled curtain. Clinic staff spoke with patients in a reassuring, considerate and respectful manner.
 - Patients who used a range of services at Bitterne Health Centre commented on the caring staff and spoke particularly about the care and support provided by pulmonary rehabilitation staff, the three patients we spoke with said staff were 'brilliant'. The cardiac rehabilitation team reported that they had received no complaints and 100% positive feedback in recent months. Early supported stroke discharge team also reported almost 100% positive patient feedback.
 - The tissue viability team had received good patient feedback in Southampton, but not in Portsmouth. We observed Southampton clinic; staff had good interaction, explanation and skin care discussions with patients, maintaining comfort and dignity throughout.
 - Snowdon at home demonstrated a caring and compassionate manner to their patients and support to their carers. They discussed the impact of their interventions on the patients' physical, psychological and emotional welfare.
 - The virtual ward team in central had received 95% positive responses to the Friends and Family test, all staff were asked to hand out two per month to ensure sufficient feedback took place. There could be a slow turnover of patients as some were with them for up to 12 weeks.
 - The Portsmouth community nursing team reported they had received no feedback from the Friends and Family Test. However, we observed community nurses delivered respectful, compassionate care with attention to their patient's privacy and dignity. A good rapport existed between nurse and patient, and any carers or relatives.

Compassionate care

- We spoke with 52 patients and 6 carers of patients, in clinics, in their own homes or by telephone. All patients we spoke with said that staff provided a good and caring service.
- We found the care and treatment of patients within all services was flexible, empathetic and compassionate. Staff had developed trusting relationships with patients and their relatives and loved ones. Throughout the inspection, we witnessed patients were treated with

Are services caring?

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated that they felt involved in their care. Patients told us the staff had explained their treatment options to them, and they were aware of what was happening with their care.
- There was clear commitment by staff in the importance of ensuring their patients understanding and being involved in their treatment programmes, as positive engagement had led to better outcomes and a likelihood of longer-term improvements for patients.
- We witnessed numerous clinics and patient groups on inspection and were impressed at the level of engagement, understanding and sensitivity shown to patients. For example, the pain team held one to one and pain information sessions for patients to help them understand their pain and make sense of the services offered and to choose their treatment. The pain team viewed this as an essential part of their pain management programme. The podiatry clinic team showed a similar caring and empathic approach to their patients.
- The neuro rehabilitation team ran a six monthly newly diagnosed Multiple Sclerosis (MS) support group in partnership with a neighbouring NHS trust. Patients told us they appreciated the information, group support, as they 'had to come to terms with the condition yourself'. All patients felt positive about the MS group, said to be caring and supportive, focused on information giving and self-management.
- Staff delivered sensitive and interactive education sessions within pulmonary rehabilitation classes to support patients in their understanding of the benefits of exercise and encouraged them to continue at home.
- Snowdon at home considered any underlying issues not admitted by their patients, which displayed a breadth of awareness and empathy. Patients and their family discussed and agreed care goals, with therapists who printed and signed them off when achieved.
- The tissue viability clinic issued patient information leaflets that included fire risk awareness of liquid paraffin, a contact number card and patients were asked to complete a friends and family test. The relatives we spoke to were complimentary of the service their loved ones had received.
- We witnessed a former patient involved with training care home staff with bladder washouts, they observed the patients' privacy and dignity and fully involved the staff

Emotional support

- Throughout the inspection, we witnessed many examples of kindness towards patients and their relatives, from well-motivated committed staff. Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns.
- We observed community nurses treated their patients with sensitivity, kindness, dignity and respect. Patients and carers felt emotionally supported and reassured by the community nursing visits. Patients told us they were very happy with the Portsmouth out of hour's team caring approach.
- We heard of numerous other examples where staff provided emotional support to their patients; Snowdon at home team considered patients spiritual needs throughout all aspects of care planning. They highlighted that family support was key in achieving goals and assessed carers for strain. The MS support group assisted with patients' anxiety and colorectal patients obtained psychological support via their CNS team or GP. SALT ran groups in association with the voluntary sector to support patients suffering with speech and language issues. The FIT team accessed spiritual support for patients 7 days a week.

Are services responsive to people's needs?

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

Summary

We have rated responsive as requires good because:

- We observed a pattern of community nursing teams that were not sufficiently responsive due to a lack of capacity to cope with demand, particularly in Portsmouth, which meant a constant overflow of unmet patient visits over to the next shift.
- Therapist staffing shortages in some teams had extended the waits for services. Some specialist services had not achieved the 18-week referral to treatment pathway.
- Information regarding the recent changes to commissioning for podiatry patients had not yet reached all patients. The trust told us they had contacted all patients and offered them the opportunity to move to a different provider or to wait to see the podiatry surgical team. Although, some patients who travelled to clinic appointments with surgical expectations told us they had not received information regarding the changes to surgical pathways.

However

- There were long delays in wheelchair provision affected the ability of community staff's responsiveness; some patients had waited up to two years for a suitable wheelchair. The demand for the service was greater than the level of commissioning. However, the monitoring arrangements and actions that trust had taken with the commissioning team had not improved the responsiveness of the service or the risk to patients' safety and well-being.
- There were many examples of responsive services and teams who worked collaboratively to meet patients' needs. They provided care close to or within the patients' home environment, and reduced hospital admissions.
- Staff considered patient equality and diversity, there were adequate disabled facilities, assistance from specialist teams with patients who had a learning disability, and translation or interpreter services when required.
- Most staff had completed equality and diversity training, 95% across all localities.

- While the trust received some complaints about the community services for adults, they could show how learning had taken place as a result, with clear actions against any themes.

Planning and delivering services which meet people's needs

- Solent provided community services for adults in two geographically distinct areas, Southampton and Portsmouth with different commissioners. The trust therefore, planned and delivered services differently in the localities. However, there were regular commissioner meetings with service leads, which consider local health needs and planned services. They aimed to work with all health and social care partners to provide responsive services to maintain health and well being, avoid inappropriate hospital admissions, and support early discharges.
- There were many ongoing challenges with the commissioned wheelchair service from a private provider. There were unclear criteria and the demand was greater than that commissioned, staff told us the trust was in discussion with the provider and commissioners. However, the actions by the trust had not resulted in an improved and more responsive service.
- The podiatry team raised concerns about the new referral criteria for commissioned podiatry, which focussed on high-risk patients such as diabetics rather than preventative or generalised musculoskeletal foot pain. Patients were re-profiled, with some removed or cancelled from the waiting list if they no longer fitted the new criteria. The podiatry team were concerned that some patients did not appear to have been informed of the changes. However, the trust told us that patient s received explanation of the changes to the commissioned pathway and details of how to access care in the future. The local commissioners communicated to the GPs with a review and discharge appointment for all patients affected, with the exception of any that had not seen for 6 months previously who were written to instead. The trust told us that patients with low level podiatry issues would no longer access

Are services responsive to people's needs?

services through the NHS. The podiatry team felt that although some areas had AGE UK Fit for Life programmes, more preventative education was needed to fill the gap.

- The trust provided bladder and bowel services in both Portsmouth and Southampton, with a senior operational lead for both. The services included a home delivery service for products in Southampton, Portsmouth and West Hants. The service had agreed with commissioners to put a hold on electrical bladder stimulation, as there was no competent staff at BHC to provide it due to vacancies. They were aware of the forward plan for patients; either for referral to the acute services or to wait for the planned extra clinics when staff were competent. The service had informed stakeholders and referrers of the issues.
- There were not sufficient resources for the speech and language service to provide a full service for patients in the West Hampshire area and the trust had served notice on the contract. The service had given notice to close mid-November 2016 and was developing appropriate safe on ward referral criteria and communication.
- The two tissue viability teams worked well together but felt that the differences in commissioning had not helped improve standards across the areas. GPs valued the service provided in Southampton, and the team wanted a similar model in Portsmouth.
- Joint strategic needs assessments across Southampton, Portsmouth and Hampshire linked the service planning. These identified the rising prevalence of chronic conditions with older age, and increased need for chronic disease management and falls prevention. The increasing number of people of all ages who lived longer with one or more long-term conditions increased the need for better co-ordinated, integrated services to keep people safe and well at home. They had focused on supported self-management and early diagnosis or interventions that minimised risks and impacts of exacerbations.
- Portsmouth and Southampton councils jointly commissioned the clinical advisory team who provided patient assessment, training and advice for staff and carers on a range of equipment, posture and positioning, that supported patients in the community.
- 'Better care' funding was used to pilot different models of an 'over 75 yrs' nursing service in the three localities across Southampton. This was for patients who did not need case management but would benefit from holistic assessment and person centred intervention at an early stage, to prevent deterioration in their health and well being. The pilot's successful outcomes had identified a need to extend the service to patients aged over 50 yrs. Many patients had more mental health and social care needs than anticipated. The commissioners planned to continue the service and the trust was waiting to respond to a tendering process to provide this.
- The services worked with private providers and voluntary sector to develop maintenance and self-help services. For example, the voluntary sector ran Parkinson's support groups with support and guidance from the specialist nurse. Community matrons and nursing teams involved community support services in caring for patients with long-term conditions and avoiding inappropriate admission to hospital. A trust exercise instructor and physiotherapist in local sports centres funded by Sports England ran 'neuro fit', physiotherapy maintenance sessions.
- The trust had created the 'stroke community rehabilitation' team and the 'Snowdon at home' team (for other neurological conditions), in line with national guidance for early supported discharge from the acute hospital. Of the patients received from the stroke ward (normally Southampton) 50% were discharged within 10 days and then supported by a six weeks therapy programme. There was a capacity of 20 patients, dependent upon clinical pressures. The teams were recently co-located with one manager to support the best use of resources for a responsive service. The Snowdon at home service for example, visited the patient up to five times per week.
- The community independence teams had integrated with existing therapists and been co located with adult social care staff to provide more seamless care for patients. Although the working relationship was new, staff gave examples of how they had started to work more closely in practice.
- Community neurological rehabilitation service had worked closely with commissioners in planning and developing services. As there was limited provision for patients with functional disorders in Portsmouth, a business case was submitted to develop a service. There was already a successful epilepsy clinical nurse specialist service in Southampton and staff wanted to replicate this in Portsmouth. Service leads and commissioners were negotiating to expand the

Are services responsive to people's needs?

neurological rehabilitation transitional team. There was a community neurological service, which covered Portsmouth and South Hants, Petersfield and Liss, with three hubs, which had 40 patient referrals per month. Three CCGs, a local acute trust and another community trust had commissioned this.

- Portsmouth city commissioned the CNS for heart failure with fixed KPIs. The CNS responded to 95 patients on their books. The nurse led clinics ran twice weekly and enabled close liaison with the cardiology team and the neighbouring NHS trust heart failure nurses. They attended the virtual ward handovers and responded promptly when needed.
- Portsmouth rehabilitation and reablement team were responsive to patients' needs across the whole 7-day period; there was a combined team of 90 staff from social services, therapy and nursing from community and within a local acute trust. Referrals came from community, GPs, district nurses, community matrons social workers and ambulance services. There was a multidisciplinary team meeting on Monday, Wednesday and Friday to discuss the 70 patients under their care.
- The frailty intervention team (FIT) team based in a local acute hospital ED restarted packages of care for patients over the weekend but could not initiate any new ones. The team also accessed carers support, Red Cross and other patient support services.
- Multiple sclerosis patients had optional hydrotherapy through physiotherapy in Portsmouth; there was a self-help group available via a local private gym. Solent patients accessed a clinical psychologist service. The focus group provided active peer support and a buddying system, which patients found valuable.
- Pulmonary rehabilitation was an integrated service, planned and delivered in partnership with the local acute hospital. Venues across the community provided a range of classes; patient questionnaires provided feedback on patient preferences. There was a reciprocal arrangement with a neighbouring trust so those just outside the catchment area were able to access a class nearer to where they lived. Following extensive evidence of the positive benefits to patients, funding was obtained to deliver singing classes.
- A community geriatrician in Southampton had negotiated access to the outpatient blood transfusion service at the acute hospital for community patients, to avoid inappropriate admissions.

- Nursing services took account of the demographics and levels of deprivation when they determined the size and make up of their teams. For example, there were identified 'hot spots' for numbers of patients with long term conditions; more older people in Southampton East; and the West had higher levels of deprivation.
- The diabetes service supported patients with education and self-management of their diabetes. They supported 32 GP practices in Southampton, with good collaboration for clients' needs, which included a patient urgent help line. The GPs, since 2014, had invited the CNS to attend their surgeries every 2-3 months, as practice nurses were the first point of call for diabetic patients, and the CNS team educated and supported them.

Equality and diversity

- Mandatory training for all staff included equality and diversity issues. The majority of staff had completed this and could demonstrate an understanding of equality and diversity.
- Translator services and interpretation services were available and well advertised, staff knew how to access them.
- All of the services we visited were accessible to patients using mobility aids by use of ramps and or lifts. Disabled parking was available at all the hospital and clinic sites we visited. We heard of one service changing its location to enable easier access for wheelchair users.
- Patients with a learning disability could either access pulmonary rehabilitation classes in a group class with support from a carer or support worker, or at home if more appropriate. Patient information leaflets for pulmonary rehabilitation were available in different languages for all other ethnicities.
- Various COPD patient information leaflets were available in English and Polish, as there was a large Polish population in Southampton. British Heart Foundation leaflets were used, as they were available in different languages.
- The tissue viability team used patient safety federation leaflets as these were available in different languages. For complex positioning of patients, they had taken photos in the past to leave in patient's homes as a resource for both carers and relatives

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- Patients with specific needs, for example a blind patient, had a home assessment before they attended a pulmonary rehabilitation class. Carers were welcomed to attend and support any patient.
- The clinical advisory team described how they balanced the support and protection of patients with their individual needs and requests. For example, we were told a younger patient was using a wheelchair that compromised their posture and made them at risk of pressure damage, but which allowed them to go out and socialise. This patient had an individually cast armchair and moulded shower chair provided for their use in the home.
- The clinical advisory team told us that basic stocks of paediatric and bariatric equipment were available and any access to any clinically justified equipment. The clinical advisory team worked with community teams in assessing equipment needs of complex patients. For example, supplying a bed of choice, moving and handling equipment for a bariatric patient receiving palliative care.
- The pain team aimed to make the service accessible to all, a support worker was asked to accompany any patient with a learning disability or if necessary treatment was continued at home.
- The frailty intervention team (FIT) based in Portsmouth ED accessed the learning disability team in core hours, to help them meet the needs of patients with a learning disability. The patient's history had a flag on the patient's records as an alert.
- Snowdon at home team supported a family who were struggling to care for a patient within the family home. They also acknowledged the need for cultural support for those who English was not their first language.
- Cardiac Rehabilitation provided a home exercise programme and access to a dietician for 8 weeks following a patient's discharge from acute care, although they admitted this programme was difficult to access for those who had returned to work.

Access to the right care at the right time

- The clinical advisory team met response times for initial contact for 99% of routine referrals (within two working days) and 98% of urgent referrals (within one working day). Routine referral assessments to the end March

2016 achieved 96%. Over both cities, there was a decline in achieving referral to assessment in the last quarter of the year. Routine referral assessments within seven working days were 88% achieved and urgent referral assessments within one working day achieved 91%. The performance to end of March 2016 was better overall at 96% and 97% respectively.

- There were varied delivery times for equipment dependent on the urgency of the order, same day, one-day or three-day response. Equipment was supplied within three hours if needed for early supported discharge from hospital. Most staff reported good access to equipment when needed.
- There were significant delays between ordering and delivery of wheelchairs and cushions from the private provider; regularly two year waits for bespoke chairs. This had affected patients; and the care and treatment that staff were able to deliver to patients. Some patients were unable to go out of the house, some used non-bespoke wheelchairs, which led to incorrect posture, risk of pressure damage, and for some this affected their breathing and swallowing. It sometimes resulted in the need for additional interim equipment, such as specialist chairs.
- The clinical advisory team told us that, some patients had become 'unseatable' or on 'bed management' due to the long wait for a wheelchair. The rapid response team told us of increased need for psychology services to support patients with a low mood because they were unable to go out of the house. Staff provided similar examples across all the teams we visited. Staff told us the issue was on the trust risk register and the chief nurse had been alerted. This was discussed with the provider and more clarity was provided on referral criteria and procedures. The community neurological rehabilitation team (CNRT) had invited the wheelchair provider to a team meeting to discuss concerns. However, despite some actions by the trust there were still significant delays; some patients waiting up to two years.
- From April 2015 until January 2016 the Portsmouth rehabilitation and reablement team (PRRT) response to referral performance from ED (within an hour) was met, on average 93% achieved. From community referral within two hours was met on average 93% achieved. Performance on response times improved through the year to 100% met for ED and 95% met for community referrals.

Are services responsive to people's needs?

- We were told that the agreed waiting times for Southampton community independence teams were not being met due to staffing shortages. The two-week wait for priority patients and four weeks for routine patients were 10 weeks in the west locality and eight weeks in east locality. Staff informed us that the virtual wards had experienced longer waits for patients already on virtual wards, partially due to increased incidence of therapy with long-term conditions.
- The waits for speech and language therapy (SALT) were high in West Hampshire and Southampton areas. There were increased numbers of breaches in the 18 week target for waits for SALT in some areas of Southampton since January 2016 and a significant number of breaches in West Hampshire, with some patients who had waited over a year for lower priority services, for example, communication support. Patients with complex needs and high risk swallowing problems were prioritised. The service lead told us there was no dietetic or nutrition nurse support in the Southampton area so SALT visited complex patients, for example those with motor neurone disease. They picked up holistic problems so were unable to address lower risk patients' communication needs.
- Podiatrists displayed an understanding of their role in keeping people mobile and independent with their interventions, although there appeared confusion over the new podiatry surgical referral pathway. The trust told us that the service had stopped receiving and accepting patient referrals, but the podiatry staff we spoke with felt this had not yet happened. They told us they had to explain to patients with surgical expectations that the surgical pathway had been changed. One example we saw, was a patient who had travelled from the Isle of Wight for her appointment and stated she 'would go home and cry'.
- Portsmouth adult bladder and bowel services, including stoma care, had no waiting time issues. In Southampton there had been an increase in waits for bladder and bowel service in 2016. In June 2016, new patients were waiting 23 weeks and follow up patients 24 weeks. Waiting times for these services were closely monitored with action plans to address areas who needed to improve. The Band 7 CNS triaged or prioritised all referrals to ensure no urgent patients were overlooked.
- The stoma care team was accessed via referral from consultant or the colorectal CNS. The team returned a call within 24 working hours from Monday to Friday. Their team was clinic based, but very occasionally would visit a patient in their home. Patients were offered a choice of clinic venue to suit their home location.
- The community stroke team took referrals from the acute hospital, for patient meeting the criteria. Historically this was between 24 hours to 110 days post stroke, 50% patients went home within 10 days. The service operated a 'welcome home' system to see patients within 24 hours of their discharge, this was met on every discharge, unless the patient refused the appointment or the team hadn't been informed of discharge. The service was available every day of the week and worked alongside the rapid response team to provide evening and weekend visits. Most patients required the six-week programme, but 25-30% required just two weeks. If patients had further needs at the end of the programme they were referred to another team such as CNRT, neuro gym, community independence team or stroke association.
- Cardiac rehabilitation saw patients within 10 days of their discharge from hospital referred by the acute trust or by their GP, they were risk assessed to join a NICE recommended exercise programme. This consisted of weekly exercise, health education and a relaxation programme, however this service was only available in Southampton not Portsmouth.
- Referrals to neuro gym services had increased by 30% over the last three years, and waiting times of 12 weeks was of concern to the therapists but was below 18 week waiting time targets. Waiting lists were reviewed and monitored every week. Urgent patients were seen within two weeks.
- The Parkinson nurse service contacted patients immediately a referral was received. They were developing a red, amber, green (RAG) rating system to prioritise frequency of visits or telephone calls, to provide appropriate care and treatment and to avoid long waits.
- In the community neurological rehabilitation team (CNRT) in Portsmouth the waiting times were six weeks or under to access physiotherapy, OT, speech and language or specialist nurses. Access to psychology was 12 weeks. Waiting times for CNRT were under 16 weeks for most services.

Are services responsive to people's needs?

- We were informed that if needed, joint visits could take place with rehabilitation therapists, social care and nursing, which meant that any interventions would start quicker, avoiding admission. The matron had direct link to GPs, which was helpful for fast interventions.
- Rehabilitation services and programmes were time limited. Staff proactively signposted patients to maintenance exercise classes and groups in the community, to maintain the benefits of treatment received from the services. The waiting list was prioritised to urgent, which was at two weeks or four weeks. We were told that demand had outstripped the capacity.
- The single point of access (SPA) was open 7am-10pm seven days a week with a responder service for new referrals enabling assessments between the hours of 8am – 8pm seven days a week. The service helped patients and healthcare professionals arrange appointments and deal with queries or questions about services. They accepted referrals and sent messages to the district nurses in Portsmouth. Provided professional diabetes advice and support with the diabetes urgent care line.
- SPA booked podiatry appointments for Southampton, Portsmouth and Hampshire; however, patients told staff that there were delays in securing appointments, with the telephone often going unanswered. Patients described waiting for six weeks to be able to book appointments due to SPA only releasing six weeks of appointments at any time. Patients then waited another six weeks for their appointment by which time they could be in pain. There was a 12 week wait across service. There was a housebound service for those patients unable to use transport.
- We saw that those podiatry patients with an 'urgent need' were always prioritised and a drop in service for urgent or unscheduled appointments was available in Southampton, although patients were advised that there was a two to three hour wait. A private provider was available and patients were advised to use, in between NHS appointments, access was through the SPA.
- Community nursing in Portsmouth did not hold a waiting list, so had difficulty in meeting daily demand. The evening nursing team who were on duty 5pm to 7.30pm asked for referrals to be made after 4.15pm so they would be picked up by the out of hours team. We observed a pattern of each shift not coping with demand, so there was a constant overflow of unmet visits to the next shift, Although most patients reported the community nurses visits to be 'on time'. One patient told us that she welcomed the home visits, as unable to leave the house and this was addressed when visits had been planned and delivered.
- Access to adult clinical nurse specialist services was generally under 12 weeks. Specialist clinical services such as cardiology, diabetes and pain management achieved referral to treatment targets.
- Ambulance Anticipatory Care Plans were used for individuals who may not benefit from transfer to hospital and to avoid unnecessary admission. The independence teams added to them where there were patients who were 'frequent fallers' who would not benefit from re referral to the team. The ambulance anticipatory care plan was a concise but thorough overview of patients' mental capacity and wishes.

Learning from complaints and concerns

- There were clear processes for dealing with and learning from complaints. Community services for adults had very few complaints, and those received usually related to waiting times, for example in speech and language services. Service team leads told us if necessary, a full investigation of complaints took place, which led to actions. For example, discussing it with the commissioners of the service, as well as meeting and corresponding with the complainants. They told us the aim of the investigations and any actions taken were to improve the quality and responsiveness of the services. Response letters to complainants included details of any organisational learning because of their complaint.
- The trust data indicated that the community health services for adults received 125 complaints from March 2015 to February 2016, which was 37% of the total complaints received by the trust. Of these were 42 fully upheld, 38 partially upheld and two were referred to the Ombudsman. However, they also received 360 compliments or plaudits, 38% of the trust total of 941 compliments received.
- The trust annual complaints report detailed actions because of complaints, for example, a trend of complaints relating to unanswered phone calls in Southampton, led to a dedicated administrator to answer calls rather than pick up messages Monday to Friday.

Are services responsive to people's needs?

- As a result of patient feedback a new uniform policy was about to be introduced to ensure clarity around roles for patients, for example for easier identification of physiotherapists and assistants.
- There were some negative comments about inpatient care in post discharge patients, and there were actions to improve with the local acute trust and Solent patients. There were some cases related to concern over the progress of their appointment in the system.
- The single point of access team told us that the electronic patient record supported those taking incoming calls, and reduced the chance of error. SPA used a daily task board and tasks that required urgent actions were requested both electronically and phoned through. The team were trained in dealing with conflict management, as they were often the 'front line' in dealing with unhappy patients.

Are services well-led?

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

Summary

We rated well led as good because:

- The trust had a strategy to provide safe care which was aligned to best available evidence.
- Staff had been involved in agreeing the values of the trust to support the delivery of the vision and strategy. Staff told us of their values and how they underpinned the way they worked in teams providing community services for adults. They told us they were asked to reflect on the values as part of the appraisal process.
- There was a well-embedded governance structure in place, this fed from locality teams upwards into the executive board. The teams used governance dashboards and a governance tracker to monitor the progress of incidents, complaints, and risks.
- Staff knew of their local risk registers and knew their highest risks that were escalated to the trust wide governance and assurance group
- Community services for adults had participated in and completed in improvement and innovation programs, including a number of CQUINs 2015-16 (Commissioning for Quality and Innovations).
- In general, the staff felt supported and listened to, with opportunities to develop and progress.

However

- Some community teams within Portsmouth expressed 'feeling isolated' with no appraisals, limited development opportunities and engagement. The new nursing management structure was causing some anxiety amongst nursing teams in Southampton, as they were concerned about losing their links with the wider MDT team. The teams described feeling quite separate across the two cities, with different working practices across Portsmouth and Southampton.

Service vision and strategy

- The trust's vision was to provide great care, be a great place to work and deliver great value for money. Its aims were to deliver care that is safe, joined up, simple and

easy to access, and based on the best available evidence. To improve staff development opportunities, staff communication and engagement, and involvement in key decisions that have an impact on services. Alongside improving use of resources, increasing productivity, reducing waste, and working with partners in health and social care. There were clear priorities to help deliver the vision.

- The vision and strategy for community services for adults was closely aligned with this. The services were working towards more integrated working. Provision of a range of responsive services closer to home, avoiding inappropriate admission and facilitating early discharge from hospital.
- The trust had recently involved staff in agreeing organisational values to support the delivery of the vision and strategy. These were referred to by staff as HEART values: Honesty, Everyone counts, Accountable, Respectful and Teamwork. Staff we spoke with were aware of the trust values and how they underpinned the way they worked in teams providing community services for adults. They told us they were asked to reflect on the values as part of the appraisal process.
- The senior management team told us that they had examined the complexities of their activities and found that unscheduled care workflows were not effective in delivering the strategy. They looked into the better management of these workflows, such as the referral pathways into community. A skill mix review revealed that clinical leadership was needed within the Southampton nursing teams to emulate the Portsmouth model and support delivery.
- Staff described different working practices across Portsmouth and Southampton. Staff knew the operational directors met regularly with their managers and they stated that their managers were very approachable. However, they were not sure information always transferred down to the junior staff.
- Although some staff stated they were always involved in service changes or development plans, others told us they had not been.

Are services well-led?

Governance, risk management and quality measurement

- We were told of the governance process in each locality and team that we visited, senior staff spoke of their monthly multidisciplinary governance meetings which were held with a standing agenda with a report based upon the five Care Quality Commission Domains; Safe, Effective, Caring, Responsive and Well Led.
- The meetings included checks on the clinical dashboards, these covered a range of quality and performance indicators which Band 7 team leaders and above had access to. They used these to identify early warning triggers and quality issues and were discussed at team meetings, with information fed into the service line governance tracker. The tracker detailed all embedded action plans, risk registers, safer staffing, complaints, carer feedback, training and development, staff feedback and checks on any audit action plans. The local governance meetings and reports fed into the 'service line clinical governance committees' for Southampton adults, Portsmouth adults, and primary care. Key representatives attended to feedback and share information. This meeting fed into the quality improvement and risk committee and the trust assurance committee, chaired by the chief nurse.
- Service leads told us the meetings with clinical directors were thorough and challenging, full response and action plans were required if there were any queries or areas of concern. The governance tracker 'dashboard' helped the visualisation at each level of governance.
- Teams described how they also used team meetings or part of MDT meeting to discuss governance issues and audit as well as operational issues; however, some teams particularly in Portsmouth reported feeling isolated and unaware of risks and any shared learning from incidents.
- Most staff could describe the use of local risk registers to highlight and escalate organisational risks to the senior team and the trust risk register and were aware of their local top risks. Managers told us that using the risk registers to show risks from the top and bottom of the organisation worked well.
- Top risks for Southampton were the numerous IT issues, as the frequent 'down time' affected patient care, particularly at BHC. We witnessed it being down frequently during inspection, which meant they had to use their business continuity plan, as there was no

phone access for patients. Poor IT affected the teams' performance in supporting patients. For Portsmouth, top risks were staffing in community nursing and delivering services with the financial gap, and specifically Portsmouth rehabilitation and reablement team (PRRT) had a high risk relating to their unplanned response to the challenges of the acute hospital.

- A range of teams told us that the issue of wheelchair delays was on the trust risk register. The risk team was collating incidents of reported delays in wheelchair delivery. Staff told us the chief nurse had held meetings with the independent provider to raise concerns, but it was not clear what progress if any, was made or action plans agreed that addressed the risks to Solent patients.
- The waiting times for SALT were on the risk register, the service lead was confident the trust board were aware of challenges and risks following their contractual notice being served and their ongoing staffing gaps.
- The senior management team told us of quality impact assessments which were completed on any transformational plan, to identify the impact on safety. An example was given, that following the instigation of BHC as the long-term condition CNS hub, a recently proposed reduction of a Band 7 post was not supported.
- The central management team monitored quality indicators. They regarded rebooked patient visits as a measure of the efficiency of the service.
- Managers attended some handovers or had twice-daily conference calls to discuss staff sickness and risk rate the service on that day.

Leadership of this service

- Each team had a team leader who provided day-to-day operational leadership; locality managers managed these. Most trust staff described their managers as approachable and supportive. The trust had invested in band 7 and band 8a managerial leadership training through an independent company, and supported leadership training for 8a and above. There was a Portsmouth two day development day arranged for band 7 with an agenda which covered the role of Portsmouth rehabilitation and reablement team, KPIs, budgets and staff management to support new managers.
- Some therapist team leads were due to attend a 'releasing potential' leadership course and had

Are services well-led?

accessed training on HR policies and procedures needed to manage a team. A senior manager told us it was difficult to release community nursing team leads for leadership training, due to staffing pressures.

- The chief executive officer (CEO), had allowed a specialist nurse to shadow them, the CNS found this was an excellent learning opportunity and provided greater understanding of trust wide and commissioning issues. SALT described the CEO was 'accessible' with good communication between them.
- A recent nursing workforce review had taken place in both Portsmouth and Southampton, which resulted in a decision to manage nursing separately. The trust had appointed new senior nurses to increase the nursing leadership.
- Previously, the community nurses and matrons had sat separately within the Southampton team, a workflow analysis had revealed variation across the city, central, east and west. They were about to be merged with the nursing services, as Southampton would have an integrated nursing management team starting the week after the inspection, who would cover the three teams in the three localities. The community nursing team discussed how the three teams would integrate and if they would feel more like a team.
- Southampton locality service managers managed community matrons and district nurses at the time of inspection. Following the co-location of social services staff to these teams, there was a transitional plan for a new leadership structure for community nursing from July 2016. This was causing anxiety amongst some staff, who hoped to keep the strong cross team working links with therapy and rehab colleagues. Senior nurses reported a listening and responsive management team and community nurses felt well supported by their line managers. Staff felt that working practices were changing as of 'tomorrow' and although consulted, felt there was little opportunity to contribute to the change. The Southampton central team had experienced multiple nursing vacancies recently and their exit interviews revealed that some staff leaving were unwilling to go through change again.
- Staff in rehabilitation, nursing and independence teams in Southampton told us they had good local managers who were approachable and visible. There was good communication and regular team meetings at local and service level. Some even had away days organised for the MDT.
- The central team in Southampton was said to have a good team spirit, with strong clinical leadership and a nurturing, trusting environment; hence there had been lots of interest from local social care colleagues to join their team. Some team managers told us that, since recent integration, it was a challenge to support social care staff in their teams, especially where they were newly qualified without a senior practitioner in the team. However, generally we found the integration was well led.
- Portsmouth teams told us they had approachable managers and the community nursing team described having current weekly meetings to manage gaps in the workforce, patient caseloads and to access support. They told us they were overworked most of the time, 'working lots of extra hours', which were not claimed back as 'impossible'. One staff member reported that they were unsure if senior leaders heard their voice, but they had an opportunity to speak through the anonymous staff survey.
- We were told that some Portsmouth nursing staff had not had expenses signed off by their line manager for over 3 months, and had accessed union support. Whilst we were on inspection, staff told us these had been done. Staff were reassured, but unhappy; they felt that the inability to prioritise staff expenses might explain some of the past difficulties in recruitment and retention of staff in this locality.
- All staff described feeling generally listened to, well supported and encouraged to progress, there were some small specialist teams in Portsmouth, who expressed views that they did not feel listened to, and felt there was no scope for promotion or growth in their roles. Some said they were not aware of who the chief nurse was or any of the executive team and described feeling 'isolated'.

Culture within this service

- We found a culture within the trust focused on the needs and experience of patients and staff were committed to helping people to stay in their own homes wherever possible. There was a supportive culture in all of the community rehab and independence teams. All staff focused on providing the best possible care for patients despite external pressures such as staffing.

Are services well-led?

- Staff we spoke to had an awareness of the whistleblowing policy, some team leaders told us they always asked staff in supervision if they had concerns about anything happening that had been harmful to patients.
- There were quarterly citywide forums for different bands of staff across Southampton these provided opportunities for reflection on case studies, peer support and interactive training.
- There was a 'lone working policy' which staff were encouraged to follow; they were provided with tracking badges which were used in emergencies. However, most staff we spoke with raised some issues regarding the tracking badges. They did not work in lifts and in high-rise buildings, which were in the community team's normal working locality. To back up the system, most teams used a buddy system to support lone working staff during the day and teams went out in pairs out of hours. Teams had also developed a variety of local systems to support staff, which had worked well in the past. Some teams reported that there were insufficient badges within their team.
- The urgent response team including the out of hour's team had recently relocated from the community hospital to a resource centre. Patients were given the contact phone number of the overnight team, who felt that a fraudulent call request could set them up to a potential visit trap. They attended visits in pairs and did not take out laptops but had past experience of incidents.
- Some SALT staff reported feeling demoralised as they felt they did not have resources to provide a service that met their patients' needs. In contrast, the neurological rehabilitation team described working in an 'open culture', really supportive within team particularly when working with end of life cases.
- The community nursing teams reported feeling that there was inequity of working teams across Southampton; some that worked from GP surgeries had little contact with other teams. The teams reported that there are unconfirmed rumours to move all community nurses to a 'case management' style, like the community matrons and staff felt unsettled by these rumours.
- The community nursing teams in Portsmouth reported feeling 'told' what would happen rather than part of change process. Some described nurses with a very low morale and high turnover.
- Team members told us that a recent merger of the frailty intervention team (FIT) Portsmouth with the rapid response team felt more like they were being 'taken over' due to the vacancies within the FIT team. They did not have administrative support, although we were told of plans to recruit a coordinator. They reported that previously there were three Band 6 posts but now had only one, and described feeling isolated and unsupported by their management line.

Public engagement

- There were many examples across the trust of patients being closely involved in service development. Community rehabilitation and independence teams engaged patients and families in developing and changing services. One example we were given was; patients helped to choose the 'best' venues for pulmonary rehab classes.
- Patient questionnaires gave regular feedback and gained patient opinion on specific issues, for example; band 3 staff in community independence teams working practice was changed following patient feedback to specific questions.
- Patient feedback from 'Have your Say' events, held in partnership with the acute hospital and stroke association, had influenced service delivery. And patient feedback on the need for maintenance physiotherapy led to the development of neuro fit sessions at local sports centres. The service also set up sessions at a local play centre for Multiple Sclerosis (MS) patients with young children, in response to patient feedback.
- Portsmouth had more difficulty in engaging with patients and carers together; recently Age UK had assisted and improved this.
- The service adopted the name of 'bladder and bowel' following patient feedback; as patients felt significant stigma attached to the 'continence service'. To enable patient choice there was a voucher scheme available for those who wanted specific continence products, following a needs assessment against criteria. Patient feedback had led to changes in stocked supply. The service involved patients in writing information leaflets, as they were keen to engage and make changes.
- There was a COPD maintenance forum, where patient representatives took part and discussed the service.

Are services well-led?

Singing activities took place every week, which assisted in extending the patients' 'out' breaths. The COPD team aimed to broaden out COPD support groups to include other community music groups.

Staff engagement

- Staff told us the CEO sent regular communications and was available once a month for online Q&A session.
- Most staff said the executive team were visible; they had visited Bitterne Health Centre, the COPD West Quay singing event and the Cardiac Rehabilitation team. Although some administrative staff felt the executive team were not visible, the Cardiac rehabilitation team told us it was better since the CEO held an 'open session' that staff accessed.
- There was a staff health and wellbeing implementation group; one team representative had started up an 'after work' exercise class. They told us the implementation group was considering issues, such as the rise in retirement age, through 'added age, added value' discussions.
- The Solent Newsletter had helped to keep staff informed of what was happening across the trust.
- Action plans were developed for Southampton and Portsmouth to address the findings of the last staff survey, there were 12 trust actions identified to address the shortfalls, five of which related to errors or near misses involving patient care. The others related to a lack of work opportunities, harassment or bullying from other colleagues, experiencing physical violence, discrimination or harassment from patients or relatives and being happy for a friend or relative to receive care.
- Services including community neurological rehabilitation used monthly survey systems to gain staff feedback and suggestions. Headline feedback was an indicator in the team clinical dashboard. They held an end of year celebration away day, where teams presented end of year reports and discussed achievements, challenges and plans for the future. The team was increasingly involved business planning and the past year had contributed to service line objectives and aligned them with team objectives.
- The trust responded to staff feedback and relocated the early supported discharge team to the Western Hospital, the main base for rehabilitation this had improved cross team working and advice.

- The trust praised the administrative staff for their resilience in moving from base to base and hot desking, although many reported finding a private room for difficult conversations an issue.
- Some community matrons reported that their roles would be locality linked with community nurses when the new senior nurses come into post; however, they felt there had not been sufficient consultation about the move.

Innovation, improvement and sustainability

- Community services for adults had participated in a number of CQUINs 2015-16 (Commissioning for Quality and Innovations). The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals). The trust reported all as achieved. These included, person centered planning, compliance with heart failure performance targets and integrated community respiratory pathway. In reach services to facilitate acute hospital discharge from hospital, a reduction in falls, and a six month post stroke review.
- Innovation was encouraged from staff members across all disciplines; we found a range of evidence of innovation and improvement with schemes to support sustainability in adult community services.
- A service lead told us of the trust vision for an IT data warehouse which would be used as a predictive tool for both quality issues and business planning.
- The clinical advisory team provided training and advice to other providers as income generation. An OT was a recently seconded, to review requests for equipment and cost of delivery times and check for clinical rationale and best value for money. This was in response to an equipment overspend in recent years, to make sure the funding was used in the most cost effective way.
- There was a research coordinator in the trust who attended team meetings, for example, the community neurological rehabilitation team meeting. There were numerous research projects, such as, cognitive impairment in multiple sclerosis and if this affected the patient's ability to engage in psychologic therapies. The community neurological rehabilitation service considered working with other trusts in succession planning for specialist posts and the creation of practice development posts.

Are services well-led?

- The trust was involved in a pilot of the 'over 75s nursing project' providing early intervention for older patients not yet meeting the criteria for current services, to prevent deterioration in health and well-being. The pilot had been evaluated by the commissioners and a tendering process was expected to start shortly.
- A new pilot of 'discharge to assess' was discussed (Hospital @Home) which was planned to be purely for patient's personal care, commissioned for a nine month pilot. The equipment and care needs of the patients' would be assessed over one week by the urgent response team and then the patient would be discharged, there would be ten patients per week, two per day.
- Portsmouth had a specialist nursing home care team; this was a combined team with Registered Nurse and Registered Mental Nurse input, to train care home staff in long-term conditions, clinical skills in 1:1 or formal training sessions. The team focused on prevention and care of pressure ulcers and care of complex patients.
- The Parkinson's specialist nurse took a lead role in region wide meetings for the Wessex wide Parkinson's excellence project.
- Both COPD and cardiac CNS teams had national award nominations linked to their KPIs, the Cardiac teams nomination was for a patient held care plan designed for their eight-week rehabilitation programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- The incidence of pressure ulcers in the Portsmouth areas was worsening.
- Not all staff were aware of the process of ordering and obtaining essential patient safety equipment, particularly out of hours and weekends

Regulation 12 (1) (2) (f) (i)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

- All premises and equipment used by the service provider must be clean.
- The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.
- Systems were not in place to ensure equipment (wheelchairs) were supplied by the service provider, ensuring that there was sufficient quantities to ensure the safety of the service user and to meet their needs.

Regulation 15 1 (a), (f), (2)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Systems were not in place to maintain securely an accurate, complete and contemporaneous record in

This section is primarily information for the provider

Requirement notices

respect of each service user, including a record of the care and treatment provided to the service user and of decision taken in relation to the care and treatment provided.

- The trust needs to appropriately monitor and manage the wheelchair service with the private provider to ensure a more responsive service and to ensure risk to patients and their quality of life is not affected.

Regulation 17 (2) (c)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- There were not sufficient numbers of staff in some community teams to meet the requirements set out in the fundamental standards.

Regulation 18 (1)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

- Not all staff we spoke to understood the full requirements of the duty of candour, including a written apology from the trust and the offer of a copy of the investigation report to the patient. Staff identified that this did not always happen in practice.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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