Good

Norfolk Community Health and Care NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community Health Services for Adults	Provider Services Trust HQ	RY3X3
Community Health Inpatient Services	Colman Hospital Ogden Court Norwich Community Hospital Dereham Community Hospital Swafham Community Hospital Kelling Hospital	RY311 RY386 RY312 RY319 RY386 RY335
End of Life Care	Colman Hospital Ogden Court Provider Services Trust HQ	RY311 RY386 RY3X3
Community Health Services for Children Young People and Families	Little Acorns, Residential Respite Squirrels, Residential Respite Provider Services Trust HQ	RY310 RY352 RY3X3
Community Dental Services	Provider Services Trust HQ	RY3X3

This report describes our judgement of the quality of care at this provider. It 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.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	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

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We found that the provider was performing at a level which led to a judgement of "Good."

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Requires Improvement

We identified some of concerns regarding the safety of services, and judged this to require improvement.

Whilst most of the areas we visited were well maintained and clean, we had concerns about Squirrels residential respite unit for children. We found it to be in need of maintenance and decoration. Some of the equipment in use was not suitable for the needs of children using the service. The Trust was already aware of the need to refurbish this unit.

Most staff we spoke with demonstrated little or no understanding of their responsibilities regarding the Mental Capacity Act 2005.

We found a number of concerns in relation to the management of medicines in the inpatient areas. Medicines were not always stored appropriately or securely and there were ineffective stock management systems in place.

The majority of staff were aware of and had access to the Trust's online incident reporting system. We saw evidence of learning from incidents to improve practice.

There were effective safeguarding policies and procedures which were understood and implemented by staff. Staff were aware of the Trusts' whistleblowing procedures and what action to take. The Trust could not be assured that all faith leaders had been subject to DBS checks.

The Trust had a 'Safer Staffing Tool' system to record the numbers of staff on duty on each ward/team. There was an escalation policy in place if the wards were short staffed. We saw the Trust were actively trying to recruit staff and the impact of this had started to be felt in some areas.

Are services effective?

Good

With the exception of the adult inpatient areas, we judged the effectiveness of services to be good.

On some of the wards we found a lack of personalised care planning. Where care plans were in the place they were not individual and lacked detail. In some care records there were no care plans to describe how patient's needs were to be met. The lack of robust care plans meant patient needs may not have been met.

Summary of findings

We found patient care and treatment was based on evidence based guidelines. The Trust had removed the use of the Liverpool Care Pathway and implemented interim guidance called, "Caring for people in the last days and hours of life."

A well regarded mandatory training programme was available. Although the Trust was not meeting its planned targets it had set, over 86% of staff were up to date with mandatory training. New staff received an induction to ensure they were able to undertake their role safely and effectively.

Staff were appropriately qualified, skilled, experienced and competent to carry out their roles safely and effectively and in line with best practice. Specialised dental treatment was undertaken at dedicated centres with the appropriate trained staff. There was effective multi-disciplinary working to meet patient needs.

Are services caring?

Good

Throughout our inspection staff spoke with compassion, dignity and respect regarding the patients they cared for. We found all of the services we inspected to be providing compassionate care.

In the children's service, staff were passionate about providing care centred on the needs of children, young people and their families. They recognised the importance of engaging with families in order to understand their situation and the support they required.

Community end of life, inpatient and adult community services were also delivering a compassionate service which also promoted patients privacy and dignity. We observed positive interactions between staff and patients in their homes and in every unit we inspected.

People were overwhelmingly positive about the care and treatment received in the community dental service. We found staff were committed to providing a specialised dental service for patients. Patients were given clear explanations during pre- assessment avoiding the use of technical terms and providing diagrams to enhance the patients understanding of planned treatment.

Are services responsive to people's needs?

Good

We judged the responsiveness of the services as good with the exception of the adult community service which we judged as requiring improvement.

The Trust monitored the responsiveness of all of its services and monthly reports were provided to the Trust board. The majority of patients were getting a responsive service. The Trust achieved the

Summary of findings

18 week referral to treatment target (RTT) with performance of 98% in July 2014. Musculo skeletal (MSK) physiotherapy, podiatry surgery and specialist nurses epilepsy management were not meeting the 18 week referral to treatment time.

Staff told us it was more difficult for patients to access the stroke pathway if they didn't start in it and we saw how this had proved difficult for one patients who had suffered a stroke. The pathway is owned by the a different NHS Trust and Norfolk Community Health and care Trust work in partnership with them.

We saw leaflets on how to make a complaint and contact PALS were available on wards and in reception areas. The Trust also kept a record of all compliments received. Over a thousand compliments were recorded during 2013/14. Staff told us there was active reflective practice and learning following complaints.

Aspects of the ward environments were dementia friendly. Most inpatient wards had garden areas with seating where patients and their relatives could sit outside. We noted that the wards at Norwich Community hospital did not have this space available.

Therapy staff did not work weekends but healthcare assistants had received training to work on exercises with patients. Staff told us that some patients were admitted to the inpatient wards late at night. The reasons were generally outside of the Trust's control but they did affect patient care.

The service planned and delivered care to meet the needs of children, young people and families. We saw good examples of how services had developed based on the feedback of patients which included extended service opening times. Health visiting teams did not always work flexibly and this was resulting in resources being wasted because patients were not attending appointments.

Are services well-led?

Good

We judged the provider as a whole to be well led but the leadership in the inpatient service required improvement.

There was an effective governance system in place which was made up of a number of committees that reported through the Trust board. We found evidence that although quality measurement was taking place, action was not taken to address the areas identified for improvement. For example medicines management, nursing documentation and care planning.

There was a Trust wide Quality Improvement Strategy in place which set out the vision and approach to quality for 1014-2016.In addition

Summary of findings

there was also an Organisational Development Strategy in place that was developed from engagement of staff. The Trust had been through a transformation programme for community services and staff told us they had been involved in the consultation.

The Trust board received a monthly Integrated Performance Report which rated key risks for the organisation.

Local risk registers were maintained but we found some risks were not reviewed in a timely manner and had been on the register for some time. The number of risks on the individual registers varied considerably. The Trust took part in a planned Internal Audit review of the board assurance framework and risk management controls during September 2014. The review identified there were no risks in the systems and processes for risk management, but there were seven risks relating to the operating effectiveness of the systems and processes. The Trust were already addressing the areas identified in the review at the time of our inspection and were making good progress.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Executive Nurse and Director of Governance, Bridgewater Community Healthcare NHS Trust

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

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

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

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

Information about the provider

Norfolk Community Health and Care NHS Trust delivers a range of community-based services to the people of

Summary of findings

Norfolk. The Trust provides a range of services, which include community hospitals, sexual health, community dentistry, services for children and families, therapies, community nursing and specialist nursing services.

The Trust has a total of 12 registered locations with the Care Quality Commission. It delivers services in people's homes as well as from the following main sites. There are nine locations with inpatient beds.

- Norwich Community Hospital
- Kelling Hospital
- Swaffham Community Hospital
- Colman Hospital
- Ogden Court Community Hospital
- Benjamin Court
- Dereham Hospital
- Cranmer House
- Little Acorns
- Squirrels
- North Walsham Hospital

The Trust employs 2,250 whole time equivalent staff working out of a range of bases across Norfolk with a population of 882,000 people.

What people who use the provider's services say

We received a range of comments from patients and their relatives, both through comment cards as well as those we spoke with during the inspection. The comments were overwhelmingly positive, with patients commenting on the quality of staff, high standards of care they had received and timeliness of accessing the right care at the right time.

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

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

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

Good practice

- The care and compassion shown to patients by staff in all of the areas we inspected.
- The service used an Electronic Palliative Care Coordination System to support the co-ordination of care so that people's choices about where they die, and the nature of the care and support they received was respected and achieved wherever possible.
- 92% of patients died in their preferred place of care.
- The Trusts mortality review process which was led by the medical director was a proactive initiative for a community service.
- The level of multi-disciplinary and multi-agency team working within the end of life service and children's service was exceptionally good.
- A 'Silver Call' daily multi-agency discharge planning teleconference had been introduced in the West Locality. This promoted patient discharges at the earliest stage possible and aimed alleviate any barriers to discharges taking place.
- A daily capacity reporting tool had been developed which enabled the managers in the Trust to have an 'at

Summary of findings

a glance' overview of the pressures staff were under and it has helped to provide managers with the information they need to be able to divert resources where they were needed most.
- The Trust had a 'Safer Staffing Tool' system to record the numbers of staff on duty on each ward. The Trust had assessed and established safe staffing levels for older people's wards The Trust provided information publicly on it's website on how staffing levels were being managed and reported on the staffing levels being achieved.
- There was an outstanding approach to the development of pathways within the school nursing team. We noted that practice was already based on NICE guidance but that work had begun on the development of a suite of evidence based pathways for the team.
- The Starfish plus team within children's services was an excellent example of a responsive service; responding to patient referrals in the same day and providing intensive care and support for children and their families.
- The ability of the community dental service to adapt care and treatment in order to meet people's individual needs was very good.
- The Trust was an integrated provider of health and social care working with Norfolk County Council. Following a Section 75 of the NHS Act 2006, the Trust had agreed a joint management structure for health and social care. Health and social care professionals will be co-located in teams and will share access to health and social care records as well as sharing referral processes and case management.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure all clinical staff understand how the Mental Capacity Act applies to their work and develop a mechanism to monitor compliance of the MCA.
- Carry out a review of medicines management to ensure there are suitable arrangements in place to safely manage medicines.
- Ensure that all patients have a clear care plan in place which takes account of their individual needs and ensures their welfare and safety.

Action the provider SHOULD take to improve

- Carry out a review of the Squirrels residential respite unit and ensure this is fit to care for the children who access the service.
- Carry out a risk assessment of faith leaders who have not been subject to DBS checks.
- Review the deployment of volunteers working in the day unit to ensure they know what to do in the event of an emergency.
- Increase the number of nursing staff who participate in clinical supervision.
- Review the need for training for staff on advanced decision making.
- Review clinical leadership within inpatient settings and ensure all clinical leaders have opportunities for leadership development programmes.
- Increase the number of nursing staff who participate in clinical supervision.
- Ensure that missed and cancelled patient appointments, particularly within the health visiting and speech and language therapy teams, are appropriately reported and monitored. And where poor service provision or patient outcomes are identified take action to improve.
- Review the implementation of the Lone Working Policy within children's services.
- Review the local audit and patient outcome monitoring initiatives in place within children's services.
- The Trust should review the arrangements in place for the transition of children between children's service and adults services.
- Review the responsiveness of the health visiting service so that services are as flexible as possible.
- Review the governance arrangements within Children's Services and ensure all staff understand their responsibilities in relation to reporting, monitoring and analysing incidents and also the reporting and review of risks.

Summary of findings

- Continue to work with commissioners of the service to consider the impact that current service gaps and ensure services are responsive to patient need. This should include, physiotherapy, podiatry, children's and adults speech and language therapy, epilepsy and Lymphoedema services.
- Develop a process to monitor access to services that are not part of RTT reporting targets such as family planning services.
- Work with commissioners to review access to the stroke pathway for patients who have not started on the pathway when they first suffer their stroke.
- Continue the action already in place to improve the staffing levels in the service.
- Carry out an audit to review the Trust performance in relation to the continuity of nursing staff within the community nursing service.
- Review the bedroom doors at Ogden Court to ensure they would be safe in the event of a fire.
- Review the storage of cleaning equipment to ensure it is not left in unsecured areas.
- Review how patients meals are stored in the ward refrigerators.

Norfolk Community Health and Care NHS Trust

Detailed findings

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We identified some of concerns regarding the safety of services, and judged this to require improvement.

The majority of staff were aware of and had access to the Trust's online incident reporting system. We saw evidence of learning from incidents to improve practice. Whilst most of the areas we visited we well maintained and clean, we had concerns about one of the children's residential respite units We found it to be in need of maintenance and decoration and some of the equipment in use was not suitable for the needs of children using the service. The Trust was already aware of the need to refurbish this unit.

There were effective safeguarding policies and procedures which were understood and implemented by staff. Staff were aware of the Trusts' whistleblowing procedures and what action to take. Most staff we spoke with demonstrated little or no understanding of their responsibilities regarding the Mental Capacity Act 2005. The Trust could not be assured that all faith leaders had been subject to DBS checks.

We found a number of concerns in relation to the management of medicines. Medicines were not always stored appropriately or securely and there were ineffective stock management systems in place.

The Trust had a 'Safer Staffing Tool' system to record the numbers of staff on duty on each ward. We found some inpatient wards were staffed by lower levels of staff than was planned. The Trust had an escalation policy in place if the wards were short staffed. We saw that the Trust were actively trying to recruit staff and the impact of this had started to be felt in some areas.

Regulation 13 Management of medicines

How the regulation was not being met**:**

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

The registered person was failing to protect people against the risks associated with the unsafe use and management of medicines.

Regulation 18 Consent to care and treatment

How the regulation was not being met:

The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Our findings

Incidents, reporting and learning

There were 318 serious incidents requiring investigation (SIRI) at Norfolk Community Health and Care NHS Trust between June 2013 and May 2014.

In July 2014, there were 36 open SIRI's that were in the process of being investigated. The Trusts performance in relation to the investigation of SIRI's was generally good with 95% of 3 day reports and 100% of 45 day reports submitted to the Trusts commissioners.

During 2013/14 the Trust implemented a pressure ulcer validation group to review the entire reported grade three and four pressure ulcers. The aim was to determine if the ulcer was avoidable or unavoidable. Available pressure ulcers in the inpatient units are those that developed where there were no appropriate assessment and treatment/prevention plans in place. In July 2014 there was one avoidable pressure ulcer in the inpatient units. The Trust had revised their prevention and management of pressure ulcers policy and the reduction of avoidable ulcers had been a priority for the Trust. All grade three and above ulcers were subject to a root cause analysis investigation and we saw evidence that staff had received learning from the outcomes of these.

Staff were aware of and had access to the Trust's online incident reporting system. This allowed staff to report all incidents and near misses where patient safety may have been compromised. Staff were aware of what should be reported and were encouraged to do so.

We saw an example of an incident that had been classified as serious which had occurred in one of the day units. We saw evidence that the incident had been discussed at the clinical governance meeting and a root cause analysis (RCA) investigation took place. There were actions for learning and development and training was implemented as a result of this. Staff told us trends in incident reporting were analysed and training was organised where necessary. This meant steps to learn from incidents were being taken.

The Trust monitored its performance in pressure ulcers, venous thromboembolism (VTE), falls with harm and catheters and new urinary tract infections using the NHS Safety Thermometer. This is a national improvement tool used for measuring, monitoring and analysing patient harms and 'harm free' care. The provider's overall rate for harm free care between June 2013 and May 2014 was below (better than) the England average during the entire 11 month period.

We found some evidence of learning from incidents within the inpatient service but this was not well embedded. Some staff told us they received feedback if they reported incidents, but some staff could not recall this. Some staff meetings recorded where lessons had been learned or the findings of root cause analysis investigations had taken place, but this was not consistent for all wards. Where incidents were reported in the children's service we saw learning took place. For example, we noted that individual incidents were discussed at local team meetings and areas for improvement were identified. One member of staff was able to describe an incidence of verbal abuse and how they fed back learning at a meeting. Within the adult community service there was openness and transparency when things went wrong. Themes from incidents were discussed at locality Quality and Governance meetings which were held monthly. The information was cascaded down to frontline staff. For example, the minutes of the meeting on 31 July 2014 evidenced a manager being designated to look at pressure ulcer incidents and gave the results of root cause analysis by the pressure ulcer validation team. This also demonstrated the Trust were learning from incidents.

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

Cleanliness, infection control and hygiene

The Trust had an executive lead director for infection prevention and control. In 2013/14, there were three reported cases of Clostridium Difficile against an annual ceiling of five cases. All reported cases were subject to Root Cause Analysis (RCA) to review lessons learned. There had been no reported cases of MRSA bacteraemia since July 2012.

Overall the standards of cleanliness and hygiene throughout the Trust were good with the exception of Squirrels residential respite unit where we noticed some dusty and unkempt areas. We raised our concerns about the Squirrels unit with the Trust during our inspection so this could be rectified straight away.

Generally, staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. We saw that staff wore clean uniforms with arms bare below the elbow and personal protective equipment (PPE) was available for use by all staff. Staff in general were aware of Trust policies and procedures and knew where to look for them on the intranet, including an awareness of the procedures to follow in the event of needle stick incidents. However, we found staff working in the blood clinic were not able to give an account of the steps to take in the event of a needle stick incident. The staff had no knowledge of post-exposure prophylaxis and were unable to show us the policy. This exposed staff and other patients to harm in the event of an incident and might create an infection control problem.

The Trust carried out 'PLACE' assessments (Patient Led Assessments of the Care Environment). Scores for cleanliness and condition, appearance and maintenance of estates were below the England average. Teams of staff as well as patient assessors completed the assessments, with patients making up at least 50% of the team. We found all of the wards we visited to be visibly clean and tidy. We saw schedules and checks in place to record that cleaning had been completed. When equipment was cleaned it was marked with stickers to confirm the date it was cleaned. A range of infection control audits were regularly undertaken using Department of Health tools. These included hand washing audits and commode cleanliness checks.

We saw that the wards we visited were clean, bright and well maintained. Surfaces and floors in patient areas were covered in easy to clean materials which allowed high levels of hygiene to be maintained throughout the working day. We saw throughout the clinical areas the general and clinical waste bins were covered with foot opening controls and the appropriate signage was used. 'I am Clean' stickers were placed on equipment including toilet seats, the resuscitation trolley and the fire evacuation trolley. This indicated they had been cleaned and were ready to be used.

We saw cleaning logs of toys within a clinic at St James, King's Lynn had not been completed. We saw that the last entry on the cleaning schedule for any toy was 2 September 2014 which was 14 days prior to our inspection. It is important that toys are cleaned between patients in order to avoid the spread of infection.

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

Where there was a possibility that patients had infections we saw that side rooms were used to limit potential infections spreading. However at Kelling Hospital a side room was being used which did not have an en suite facility. A dedicated toilet had been identified by a poster but the patient had to cross a corridor by a nurses station to access the toilet. We did not think the signage would necessarily ensure that other patients would not use the toilet. An alternative side room with an en suite toilet was available but was not being utilised for this patient. This meant there was a risk of cross infection to patients and staff.

The patient meals were supplied by an off-site catering company and the meals were required to be stored in fridges or freezers within the hospitals. At Dereham Hospital, Ogden Court and Norwich Community Hospital we saw food supplies were stored in publicly accessible areas in unlocked fridges and freezers. There was no risk assessment in place to consider and mitigate the risks of theft, contamination or electric sources being switched off.

There were on site designated decontamination rooms in the dental services for the cleaning and sterilisation of instruments at each of the clinics we saw. In one centre

several treatment rooms shared one decontamination room. We observed contaminated instruments were transported between the treatment and decontamination rooms in covered containers in line with best practice.

Staff were able to demonstrate and explain the procedures for cleaning and decontaminating dental instruments and equipment. Staff demonstrated an in depth knowledge of HTM 01-05 (a guidance document released by the Department of Health to promote high standards of infection prevention and control). There were process maps clearly displayed in decontamination rooms describing each stage of the decontamination process for staff to refer to. We saw all sterilised instruments were stored in sealed pouches and date stamped. There were checking systems in place to ensure supplies of sterilised instruments were in date. We saw records were maintained of all the safety checks of decontamination equipment undertaken on a daily basis to ensure equipment was effective and fit for purpose prior to use.

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

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

Maintenance of environment and equipment

We were concerned about the environment and equipment at Squirrels which was a residential respite unit. We saw that the sensory room in this unit was out of use and that equipment within it had not been maintained. The bathroom was extremely dated and there was insufficient space to manoeuvre wheelchairs and shower trolleys. The bath appeared to be an adult bath and it was noted this could be overwhelming for a child. The garden was large but inaccessible due to long grass, mole hills and lack of even surfaces to move wheelchairs. There was a large broken and rusty swing and a summer house which had been turned into a storage unit and was not available to the children to use for play. The kitchen was dated, poorly designed and difficult to keep clean due to lack of storage and surface space. There was a very small area in which to prepare gastroscopy feeds.

The environment overall needed improving. We noted that several areas were cluttered with surplus furniture and equipment. All areas required decorating; several bedrooms had large stickers which were peeling off the walls and one bedroom was seen to have curtains with missing hooks. These were ill-fitting and hanging off the curtain rails. Staff told us that they did not have access to resources to fix basic maintenance problems and that there was no regular maintenance to the building. We were told the grass had not been cut for two months.

We raised these concerns with the senior management team in the Trust. They provided us with evidence that they were aware of the need to refurbish Squirrels. The Trust estate was transferred from a former NHS organisation into Norfolk Community Health and Care Trust during 2013. Following the Trusts due diligence, the Trust carried out a survey of all of the estate. This identified that Squirrels residential respite unit required refurbishment. Capital funding was approved by the Trust board in March 2014 with an initial plan to have the work completed by 31 March 2015. Following our inspection the work was brought forward and was due to commence in October and November 2014. We saw evidence the Trust had obtained costings for the work from architect in July 2014 which included refurbishment of the kitchen, toilets, bathroom, sensory room as well as the creation of a clinic room.

The Little Acorns, residential respite unit was a contrast to Squirrels. It was in better decorative order, the garden and outside areas were maintained and accessible, and the kitchen and bathrooms were appropriate to meet the needs of children receiving care and support.

We saw some equipment which staff told us had been decommissioned. At Norwich Community Hospital there was no signage was in place to indicate a fridge had been decommissioned. We found a urine sample in this decommissioned fridge which should have been sent to the laboratory. The unlabelled sample had been in the fridge for four weeks. We also saw a bath which had been decommissioned for a year but this was not clearly stated so there was a possibility staff would use this.

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

On Beech Ward at Norwich Hospital, staff told us that storage was limited. This meant a patient quiet room was being used to store food and equipment and the room was no longer used as a patient area. Staff reported to us there were delays in getting broken equipment repaired. We were given examples of a bed being broken for four months. We saw one patient was using a chair which required repair. The tracking hoist at Swafham Hospital was out of order with no planned repair date. A bed on Beech Ward had been broken for two months. We were given examples of blinds requiring repair for three months on Alder Ward and at Ogden Court there were two blood pressure machines that were not working.

On an evening visit to Ogden Court we observed that some patients had their bedroom doors open through choice. The doors did not have any closure devices to ensure they closed if the fire alarm was activated. We also observed that some doors had damaged strips which were designed to reduce the spread of smoke should a fire occur. This meant there was a risk that patients would not be sufficiently protected from the risk of smoke inhalation should a fire break out on the ward. We asked the Trust senior management team to review this potential risk.

At our two visits to Ogden Court we found unlocked cupboards containing chemical cleansers and products which were considered to potentially hazardous to health as well as some sharp items. As these were unsecured they were potentially accessible to patients who might be confused. This meant there was a risk of harm to patients.

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

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

Medicines management

At Priscilla Bacon Lodge, there were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. Staff followed clear guidelines for prescribing medicines for patients receiving end of life care. Records showed anticipatory planning was undertaken to reduce the risk of escalating symptoms. Appropriate systems for the safe custody and checking of controlled drugs and syringe drivers were in place which reduced the risk of inappropriate use.

In 2011, the National Patient Safety Agency recommended that all Graseby syringe drivers should be removed by the end of 2015. The Trust had undertaken this and the McKinley syringe driver was now used throughout the service. We observed a community nurse administering medicines through a syringe pump to a patient in their home. We saw the completed records which had been signed and dated following administration.

Medicines were not always stored securely. At Norwich Community Hospital we saw medications stored openly in a treatment room which was accessible to housekeepers, porters and other non-clinical staff. Nurses told us this was due to a lack of lockable storage being available.

Staff on one ward told us that some bedside medication lockers were not being used as the keys were lost. A master key which fitted the remaining bedside lockers which were in use was also on the lost bunch of keys. This meant there was a risk that the lockers that were in use were potentially unsecure. This had not been reported as an incident.

At Ogden Court there was no lock on the treatment room door. Medicines were locked in cupboards but there were sharps bins and other equipment in this open area which had the potential to cause harm to patients. At Pine Lodge the treatment room door was propped open and unlocked cupboards were found with intravenous fluids and other medicinal products such as enemas and suppositories. We found the medicines refrigerator on Beech Ward was not

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

locked when we visited as part of our unannounced inspection. The room was accessible to porters, housekeeping staff and healthcare assistants who should not have access to medicines.

During our announced inspection to Beech Ward we saw that oxygen cylinders were dirty and highlighted this to a member of staff. On our unannounced inspection we found this had not been addressed. Staff told us oxygen cylinders were brought in from outside by porters but were not cleaned. There was a risk that dust particles could be inhaled by patients who already had breathing difficulties. Staff on the wards were not clear who checked if the oxygen cylinders were full and there were no records to evidence that checks took place. One oxygen cylinder was empty at the announced inspection and remained so at the unannounced inspection.

We saw that there was some recording of fridge temperatures but it was not consistent in all areas. On some wards nursing staff checked fridge temperatures and on other wards housekeepers were delegated this task. We found there were days when the temperatures were not checked. On Beech Ward and Ogden Court the temperature had exceeded the accepted maximum temperature for a number of consecutive days but the procedure to escalate this had not been followed. If medicines are not stored properly they may not work in the way they were intended and they so pose a potential risk to the health and wellbeing of the person receiving the medicine. In the community dental service we found there were no daily temperature checks made of drugs stored in the drug refrigerator. We also found a medicine that was marked to be stored in the fridge but was not. In addition to the fridge temperatures, there were no checks in place to check and record the temperature of the medicine storage rooms. Medicines are required to be stored at certain temperatures and if the room exceeds the temperature the medicine can be affected. We saw a medication audit had been completed in 2013 which had highlighted the poor record keeping of fridge temperatures. It was rated as a red (High) risk and an action plan for improvement had been produced. This meant the findings of the audit had not been acted upon.

Most medication administration records were fully completed or had occasional gaps apart from Swafham Hospital, where we found three out of the four medication records we looked at had signatures missing to say that the medicine had been given to the patient. This meant it was not possible to confirm if the patient had received their medicines or not. Some ward managers audited medication administration records and reported omission of signatures as incidents but this was inconsistent and was not part of the Trust's regime of audits. This meant there were no Trust wide systems in place that were effective in identifying medicines omissions. There were no specimen signatures available to ensure that a check could be completed to establish who had given medications to patients. Some signatures were available in care records we were not assured that this included all the agency and bank staff who administered medicines. A specimen signature list of those staff could order medications was kept at the pharmacy.

The Trust policy described that controlled drug stock balances should be checked weekly. Some wards checked their controlled drugs daily, others weekly and on some wards there were no regular balance checks being completed. At Pine lodge, Colman Hospital, we saw there was a period of three weeks when no controlled drug stock balances had been made. At Swafham Hospital we saw medicines in stock where the pharmacy dispensing labels had been removed. This meant that it could not be established where stocks originated from, the date they were dispensed, or how they had been obtained.

At Swafham Hospital we found out of date medicines in stock cupboards, this meant the stock checks were ineffective and there was a risk patients would be given medicines which were out of date.

The Trust obtained supplies of medicines and pharmacist advice from two nearby acute Trusts. Staff told us pharmacists and pharmacy technicians visited the wards on a weekly basis. The nursing staff we spoke with were not clear on what the role and remit of the ward pharmacist was.

The Trust had a self-medication policy in place but there were no patients self-medicating on the wards we visited.

At Norwich Community Hospital staff used a small plastic basket to transport medicines around the ward. At two separate visits to both wards we saw tablet strips and odd loose tablets out of their original packaging. This meant batch numbers and pharmacy instructions/labels were not available. One ward manager told us that this procedure had been risk assessed but this could not be located.

Requires Improvement

Are services safe?

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We observed that staff were kind and patient when giving medicines to patients. They also stayed with patients to ensure that medicines had been taken. "Do not disturb" red tabards were available to encourage staff were not distracted when giving medicines. On Alder ward we observed only one out of three staff wearing these when doing medicine rounds. A staff member from another ward told us they were not effective at ensuring staff were not disturbed.

We had concerns about medication systems at Squirrels, residential respite unit. We found that the drugs cupboard was overfilled with medications (these medications were brought in by families) and it was felt this made checking medication details challenging. We noted that medications were prepared on a wooden cabinet which would be difficult to keep clean. Whilst we noted transcribing happened and was checked by two members of staff, the designation of the members of staff undertaking the transcribing was unclear.

We found there was an inadequate system for the management of controlled drugs at the Squirrels residential respite unit. There was no controlled drugs register and whilst at the time of our visit, no children were prescribed such drugs, controlled drugs could be brought in at any time. We were told that a pharmacist had not visited the unit in the past year.

Safeguarding

There were effective safeguarding policies and procedures which were understood and implemented by staff. We saw the safeguarding policies were easily available for staff. The Trust had a whistle blowing policy and staff told us they would feel able to escalate any worries they had. The Trust had a safeguarding lead and staff knew who this was. They gave us examples where they had sought advice if they were unsure of how to handle situations. We saw safeguarding procedures and incidents had been discussed at team meetings. Staff told us they felt confident reporting concerns about safeguarding and we saw evidence of this and how local procedures were followed. Staff also demonstrated their understanding about safeguarding children and we saw the children's safeguarding policies were also available.

Staff demonstrated a good understanding about safeguarding adults and could describe different types of abuse and what action they should take. Safeguarding adults and children's training was mandatory for all Trust staff. Clinical staff were also required to complete level two safeguarding training. According to the Trust's annual quality report for 2013/2014, more staff received training in safeguarding adults and children. In March 2014, 80.82% of staff had been trained in safeguarding adults and 86.6% of staff had been trained in safeguarding children. The clinical staff we spoke with all said they had received safeguarding training.

The Trust had a chaplaincy service which was provided by the Norfolk partnership and covered all of the NHS Trusts in Norfolk. The Chaplains had been subject to Disclosure and Baring Service checks (DBS) checks as part of the recruitment process. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

The chaplains were supported by multi-faith leaders who provided spiritual support as required by patients. There were four faith leaders who were regularly called upon to provide spiritual support; these include the Rabbi, Immam, and a Catholic priest. These religious leaders had been DBS checked with their employing organisations. There could be requests for support from 30 multi-faith leaders who could be called on from the community but the Trust could not be assured these faith leaders had been subject to DBS checks.

The Norfolk chaplaincy planned to ensure all multi faith contacts had a DBS check in place by December 2014. Until this time the Norfolk chaplaincy had a procedure in place to ensure that a member of staff oversaw visits by faith leads when they are in direct contact with patients. If the patient requested a private meeting with the faith lead this would occur in a room with a glass observation panel in the door and a member of staff would be within calling distance. If the patient was seen on the ward they would have their call bell to hand. We did not find evidence of this risk on the Trust risk register.

During our inspection to the inpatient wards we raised some concerns from a patient that had been brought to our attention. The Trust responded to this in accordance with their own policies.

Records, systems and management

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

Requires Improvement

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We looked at eleven sets of patient medical notes and reviewed the DNACPR (do not resuscitate in the event of a cardiac arrest) documentation. Of the eleven sets of notes nine had DNACPR documentation in place; the other two sets of notes did not contain any DNACPR documentation. We raised this with the staff responsible for the patient's care who were unsure why the DNACPR form was not readily available

Of the nine documents we found all were located in the front of the notes so they could be easily seen. They were legible and had been completed by a senior doctor. We saw four of the nine forms had been discussed with the patient as well as with family members. One had been discussed with family only as the patient was said to 'lack capacity', however, we could not find the patients mental capacity assessment in the medical notes. We raised this with the staff responsible for the patient's care who were unsure why the mental capacity form was not readily available.

The Trust's audit of DNACPR's in patients' medical notes for May 2013 showed that at Priscilla Bacon Lodge, 100% of patient's notes had a DNACPR in them.

In most areas, we saw that records were secured in a manner which protected patients confidentiality. However, there were some risks to patient confidentiality at nurse's stations at Swafham Hospital and Norwich Community Hospital. Here we observed some notes on open work desks, shelving and unlocked trolleys when no staff were in the vicinity.

Staff handover information was provided to staff in printed formats. These reminded staff of the importance of confidentiality. At the end of each shift, there were confidential waste bins available for staff to dispose of the records.

Our observations of records were mixed. Some records were well kept and there was clear and detailed information, other records were less clear and there were omissions and gaps. We noted some of the photocopying of documents, such as those used for risk assessments were of poor quality.

An electronic information data base, communication and booking system was used by the majority of the children's' services. We were told that significant improvements had been made to this system since its implementation. We heard of various projects which had been initiated and completed by the staff to aid better information sharing and cross-working with other healthcare professionals. Staff agreed that more work was needed but that systems were improving. It was noted however that in some areas connectivity to the system could be problematic which sometimes impacted on the workload of staff.

We looked at staff records within the dental service and saw appropriate checks had been completed prior to employment such as checking professional registration and disclosures to ensure people were cared for by staff with the appropriate qualifications and who were fit for employment.

Paper records were stored securely in clinics and health centres. We saw community nursing and administrative offices had computer terminals as well as paper records. There were key coded locks on the office door for additional security and electronic records were protected by password access. Generally, records were stored securely in the inpatient areas we visited.

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

Lone and remote working

We asked about the lone worker policy and were told that at present the Trust were piloting a lone worker device within the end of life care service. There was a centrally held diary for the Palliative Specialist Nurses and the teams were to telephone into base at the end of each day.

We spoke with a community nurse who often worked in isolation said she knew there was a lone worker policy but stated that this was not always followed in the community. We also spoke with another community nurse about the lone working policy, she said she was aware there was a policy. The nurses had informal arrangements to check on each other but there did not appear to be a structured arrangement as per the Trust policy.

One team of community staff told us they phoned each other if they were late getting back to the office and two therapists who worked closely together were in constant contact with each other daily to update themselves in regard to home visits. We were told staff also used text

messaging to report their whereabouts and to confirm they had returned home safely. Staff said this worked well for them and they felt safe using this system. However, not every member of staff felt the lone working arrangements were enough to make them feel safe, especially when working on dark evenings in areas where they felt vulnerable. Community nursing staff had access to a work mobile phone.

There were also inconsistencies in how the lone working policy was applied throughout the children service. Some members of staff told us that they relied solely on a diary system so that other members of staff were aware of where they were. Other members of staff told us that had set up a buddy system so that each day members of staff would contact each other to let them know they were safe at the end of the day. When we consulted the Trust's Lone Working Policy we found that it said that diary/movement sheets should be in place and where staff worked outside normal hours, arrangements should be made for that member of staff to make contact with a manager/colleague in order to let them know they were safe. We noted this was not always happening.

Assessing and responding to patient risk

We spoke with two volunteers at the Priscilla Bacon Lodge Day Hospital known as The Rowan Centre Day Unit who had been volunteering at the unit for the past 12 years. The volunteers expressed concern that they were left alone with the patients for about an hour while the staff all attended a staff meeting. They were unsure what to do in case of an emergency, although one volunteer was aware there were panic buttons and another volunteer told us they would run to the office where the meeting was being held to get help.

Staff used an early warning system to record routine physiological observations such as blood pressure, temperature and heart rate. These were known as 'early warning scores', and were a recognised tool used to identify when patients were deteriorating. We saw where patients warning scores had escalated, staff had taken suitable actions to seek medical advice.

There was a standard range of risk assessments available which staff completed. This included moving and handling, bedrails, tissue viability and malnutrition screening. In most care records we looked at these were completed and updated but we did find care records within the inpatient areas where all of the expected risk assessments were not in place. For example one patient had been identified as having sustained a fracture after a fall but they did not have a risk assessment in place to identify and reduce their further risk of falls. We saw another patient whose pressure ulcer risk assessment document was not accurately completed so their risk score was not correct. This meant risk might not be identified, reduced or prevented.

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

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

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

Individual teams demonstrated ways they assessed and responded to risk in order to provide a safe service for children, young people and their families. For example, health visitors had frequent allocation and caseload meetings to discuss individual patients and agree interventions for at risk children. Staff we spoke with during the inspection were clear about the Trusts "no access policy" and that two missed visits would prompt an escalation to a safeguarding concern. This was good practice.

For patients undergoing specialised dental treatment they attended a pre-assessment visit with one of the dentists to understand their medical history and identify any individual risks prior to deciding the appropriate course of treatment. Information leaflets and notices were displayed to remind people of the importance of notifying their

dentist if they were taking oral anticoagulants and the associated risks. Where people were treated in their homes the dentist ensured people had written contact details about how to obtain urgent help via the out of hours service.

Staffing levels and caseload

The Trust board were aware of the challenges regarding maintaining safe staffing levels. A letter had been sent from the Chief Executive to all staff in August 2014 acknowledging the concerns staff had raised and described how they were going to address them. The Trust had a 'Safer Staffing Tool' system to record the numbers of staff on duty on each ward. This was accompanied by an escalation procedure on how concerns were to be handled. Staff told us that repeated attempts to recruit staff had been made to address staffing levels but these had largely been unsuccessful.

There was a Trust wide safe staffing reporting mechanism in place. This was reported to the Quality Risk and Audit Committee (QRAC) on a monthly basis. On every shift the nurse staffing levels were reported using a green, amber, red and black alert system (GARB). Each ward had an identified staffing establishment which was based on the acuity and dependency needs of patients. The Trust had used a recognised safer staffing tool to help calculate the staffing levels. If the levels of staff fell below this level or the patient acuity and dependency increased the nurse in charge assessed the risk and escalated it in accordance with the Trust policy. For example, a black rating would indicate the levels of staff were unsafe and mitigating actions such as altering staffing skill mix, staggering shift times or pausing admissions would be implemented.

The safe staffing report to QRAC for September identified 12.5% of all of the 1173 shifts of care across all inpatient and respite units required a variety of local actions to be taken in order to maintain safer staffing levels.

Agency and bank nurses were frequently used to fill gaps on staff rota's. Staff reported there had been some problems with staff not arriving for work as planned and not being available to cover shifts at short notice but some staff told us the bank staff provided good support. We spoke with one bank nurse who told us she had been made to feel part of the ward team and had good opportunities for training and development.

The grades of therapists working on wards varied. Some wards had band 5 therapists providing the majority of patient care whereas some wards had band 6 therapists. Staff on some wards told us they felt that some therapeutic risks were not always taken as the junior staff did have the confidence or experience to take these risks. However the therapy staff told us they did feel supported and they had access to more senior staff. Therapists had regular supervision of their practice.

Staff told us that there were delays admitting patients to Ogden Court because of the staffing levels. This meant that although patients were not able to be admitted to the unit, steps were being taken to ensure staff could safely care for the patients who were on the ward. Whilst we were at Ogden Court an afternoon admission was refused because of the staffing levels and the risk this posed.

There had been a recruitment drive across all health visiting teams, particularly in relation to the "Call to Action plan." Call to Action was a government initiative to expand and strengthen health visiting services. We saw the Trust was currently on target to meet optimum staffing levels within this team by March 2015. At the time of our inspection the Trust employed 138 health visitors against a projected number of 169. The Trust had an agreed trajectory and action plan in place which was monitored by NHS England.

However, we heard that staffing levels within the health visiting team were problematic and were impacting on the delivery of patient care. We were told by one team that a decision had been made to suspend all antenatal visits for a period of three months in order to meet targets in the Healthy Child Programme. Another team told us due to capacity they could not see all the children that were due to have one and two year developmental checks. At the time of our inspection there were 24 one year old child, and 314 two year old child development checks outstanding in the west locality alone. To ensure children remained safe we noted that a risk based approach was taking place to determine which visits could be postponed.

Staff also raised concerns with us about the four month old visits that were almost never attended and when they were, they were often undertaken by nursery nurses rather than health visitors. Staff felt that these visits were key in assessing early intervention requirements, specifically around weaning and development. The number of nursery nurses in post was due to be reduced by 30% by 15 October

2014. There were concerns that the work that was being undertaken by these members of staff would fall back to health visitors and further increase capacity demands that they would be unable to deliver.

We were told that caseloads were weighted and based on the skill mix of staff. We noted that caseloads ranged from between 166 and 410 children per health visitor, with the average being 299 children. However caseloads were generally "corporate" which meant that workloads were based on staff capacity and case complexity. By allocating caseloads in this way, staff were able to respond and deliver care based on risk ensuring that sufficient time was allowed for each individual patient.

Concerns were raised with us by the speech and language therapy team (SLT) who felt that staffing levels were not appropriate to meet the needs of the children within Norfolk. Staff told us that there was no consistency with the staff that children were able to see. It was felt this was detrimental to a child's needs because they were unable to build relationships. We saw this had impacted on staff morale and the service had seen an increase in complaints. One member of this team who we spoke with told us they were currently covering two caseloads.

We reviewed an update on children's SLT services which was presented to the executive delivery team (EDT) in September 2014. The paper acknowledged the children's Speech and Language (SLT) workforce would have fallen from 44 whole time equivalents (WTE) in April 2013 to 28 WTE by 1 October 2014. A further 1.1 WTE had been identified for removal in September 2016. The Trust had received advice and support from the Royal College of SLT and has implemented a range of changes in order to provide a service with reduced capacity. For example, a targeted training package for preschool settings to upskill the workforce and reduce the number of referrals made to the service and a triage process for all referrals. The report identified that there has been a reduction in 20% of referred casework and as more initiatives were introduced further reductions will be made.

At the time of our inspection we heard that there was a shortage of paediatricians within the service and that locums were currently being used to fill gaps. This had an impact on the service's budget and impacted on continuity of care for patients. We were however told of initiatives being looked at to address this issue which included the development of a nurse consultant role.

Other services such as Starfish and Starfish Plus were adequately staffed and worked well to meet the needs of their patients. The residential respite units were generally staffed in line with a safe minimum level; however we heard that on occasion the units had had to close due to a lack of staff. This was corroborated by a parent we spoke with who told us that at Squirrels specifically they felt "nervous" when they left their child. This was because they were anxious the unit may close and this impacted on the parent having a worry free break.

Both the staffing levels in the community dental service and the skills of staff were able to meet patient's needs. The dental services in the Trust were meeting the Department of Health's expectation in dentistry (A review into NHS Dentistry-The Steele Review 2009). The staff told us they felt their staffing levels were adequate.

Some managers and staff within the adult community service did express concern regarding staffing levels and these had been ongoing for some time. We saw that the Trust were actively trying to recruit community nursing staff and the impact of this had started to be felt in some areas. The Trust were considering a recruitment campaign outside of the United Kingdom to help them address their recruitment challenges. The vast majority of staff as well as senior managers in all of the localities confirmed the staffing levels had improved recently and staff felt confident these improvements would continue to improve as more staff were recruited.

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

The staffing model had been rolled out in the North and the Norwich localities. We saw how this worked in practice and spoke to staff and managers about the difference it was making to both themselves and their patients. The model set out the daily capacity available. All referrals for community services were triaged by a hub. The was a group of experienced staff who decided what the appropriate member and grade of staff should be allocated to each visit. The model built in break times and time for

indirect activities such as records, team meetings, supervision and training and development. Each team member had a set level of activity each day. Although it was recognised by everyone in the Trust that there had been some initial difficulties with the system, staff were overwhelmingly positive about it and thought it would continue to develop further. One member of staff said, "It's great because if I'm getting behind with my visits, the staff in the hub know and they can redirect my work."

Staff in some of the specialist areas expressed significant concerns about staffing levels The community specialist clinics such as Dermatology, Lymphoedema and Epilepsy were managed by a maximum of two specialist nurses. Most of these clinics ran without any administrative support and problems arose when staff went on annual leave or were off work due to sickness. The staff working in the community epilepsy service told us they were concerned about the sustainability of their service. We noted one of the epilepsy nurse specialist had published articles in nursing journals and had won an award for her work setting up an epilepsy training programme for student nurses.

The speech and language therapy (SALT) staff in the neurological clinic (St James, King's Lynn), expressed concern about their staffing levels. In addition to seeing patients in clinic, the team of two were also required to visit other patients in the community who required a SALT assessment. At the time of our inspection there were 67 patients on the waiting list to be seen by a SALT.

We met with two speech and language therapists providing care to people within the Norwich and surrounding areas. The team were currently meeting their waiting time targets of two weeks for urgent referrals and 14 weeks for routine referrals. However follow up appointments were often cancelled in order to meet the referral targets. They told us there was an emphasis on meeting the referral targets for new referrals. This meant there was a risk people were not receiving the on-going care and treatment that they were assessed as needing. Staff told us their administrative support time had been reduced and this had impacted on the team. They felt they had to work additional hours to ensure that people's medical records were accurately written up. These members of staff also raised concerns that their caseload management time had recently been reduced to one and a half hours per month. This meant that one therapist with an average caseload of 130 had less than one minute per month to review the treatment of each patient they were caring for.

The Neurology Clinic in Wymondham Health Centre was managed by two specialist neurology nurses, supported by the hospital consultant and four GPs. Patients were seen for their initial appointment within 6-8 weeks. However the caseloads of the specialist nurses were large and totalled 880 patients. This had resulted in the waiting time for follow up appointments increasing from 6 months to 8 months for patients to be reviewed. The staffing levels had not increased to reflect the increased number of patients.

Medical staffing

Medical cover for wards was provided for the working hours of 9.00hrs 17.00hrs Monday to Friday. Medical cover for out of hours non-urgent needs was provided by GP's. For medical emergencies staff dialled 999. Patient's care was consultant led with ward rounds being held weekly. There was currently some locum medical staff proving medical care for patients due to gaps on the rotational medical staff cover. Staff told us this did affect continuity of care for patients. The Trust had difficulties recruiting to permanent positions.

Deprivation of Liberty safeguards

There were no patients with deprivation of liberty safeguards in place within community or end of life services at the time of our inspection. Staff were familiar with the process of referral to apply for Deprivation of Liberty restrictions and a policy was available which described examples of potential deprivations. Staff gave us examples of where applications had been made and approved. Staff also told us about circumstances where they had sought advice for the safeguarding lead, for example regarding the use of bedrails.

Most staff we spoke with demonstrated little or no understanding of their responsibilities regarding the Mental Capacity Act 2005 and did not know what to do when patients were unable to give informed consent. Not all staff understood the concept of Depravation of Liberty Safeguards and Best Interest decisions.

On all inpatient wards we found inadequate arrangements to ensure patient's rights were protected when they were unable to give consent to their treatment. The Trust policy described that staff in direct patient care would be required

to undertake Mental Capacity Act training every 3 years. It described that a two stage capacity assessments should be undertaken if it was suspected that a patient might lack capacity to make decisions. We did not find any completed two stage assessments within patient's records at any of the wards we visited despite some records stating that staff regarded patients did not have capacity to consent.

Staff we spoke with showed a poor knowledge of the Mental Capacity Act and most said they would undertake memory testing as a tool to establish capacity. In isolation, this is not a robust or recognised method of assessing capacity and is not decision specific. Staff we spoke with were largely not aware of the two stage assessment process. Most staff told us that they would refer to medical staff or social services to undertake capacity assessments if they felt patients lacked capacity. Staff were largely unaware of their personal responsibility to obtain consent for the care and treatment they were providing.

The majority of staff we spoke with did not think they had not received any training in the Mental Capacity Act 2005 and this was not included in the mandatory training programme. We asked the Trust to provide us with information regarding the number of staff who had received training in the MCA. The Trust had records of 787 members of staff completing MCA training, either as standalone training or as part of their induction package. This equated to 59% of all clinical staff working in the Trust. From April 2013 until December 2013 the MCA training given at induction was not recorded. The Trust provided a plan describing how a training programme was to be implemented by March 2015, which aimed to ensure that 90% of staff would be trained in the MCA.

We did not find any evidence to suggest how the Trust monitored compliance with the Mental Capacity Act.

Generally we found therapists documented how they had obtained the patients consent. This was less clear in nursing records. We found little evidence of consent to different treatments being documented such as insertion of naso-gastric tubes, blood tests or a catheterisation. We found the speech and language therapy team at Norwich Hospital had a good understanding of the Mental Capacity Act.

We saw an example in a set of care records within the inpatient wards where patients relatives had been involved in future care arrangements. It was not clear from the records available if the patient had been consulted, or asked for their agreement regarding their relative's involvement. It was also not clear if the patient had capacity to make decisions. In one care record we saw that a best interests meeting had been held without there being evidence of a mental capacity assessment. We established that this had been completed by the social worker; however, the best interests meeting did not document clearly what options had been explored for the patient's future care.

Managing anticipated risks

Each ward had a resuscitation trolley with a defibrillator. We saw these were mostly checked daily to ensure they were working. At Ogden Court however these were checked weekly. All staff received basic life support training as part of the mandatory training so knew how to use the equipment. In the event of a medical emergency, staff dialled the emergency services as the hospitals were not equipped or suitable to provide acute care to patients. We saw this happen during our unannounced inspection and the emergency ambulance arrived to transport a patient to the acute Trust.

Patient's wrist bands provided information to staff if they had any known allergies.

Major incident awareness and training

Contingency plans were in place in the event major events, such as outbreaks of flu or winter weather affecting staffs ability to travel

Each inpatient area had a business continuity plan which detailed what staff should do in emergency situations such as utility failures.

Are services effective?

Good

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 of findings

We judged the effectiveness of services to be good. We found patient care and treatment was based on evidence based guidelines. The Trust had removed the use of the Liverpool Care Pathway and implemented interim guidance called "Caring for people in the last days and hours of life."

The care and treatment provided achieved positive outcomes for people who used the service.

On all wards we found a lack of personalised care planning. Where care plans were in the place they were not individual and lacked detail. In some care records there were no care plans in place to describe how patient's needs were to be met. The lack of robust care plans meant patients needs may not be met.

A well regarded mandatory training programme was available. Although the Trust was not meeting its planned targets it had set, over 86% of staff were up to date with mandatory training. New staff received an induction to ensure they were able to undertake their role safely and effectively.

Staff were appropriately qualified, skilled, experienced and competent to carry out their roles safely and effectively and in line with best practice. Specialised dental treatment was undertaken at dedicated centres with the appropriate trained staff and support systems to ensure patient safety. There was effective multi-disciplinary working to meet patient needs.

Norfolk Community Health and Care NHS Trust was not meeting the following regulations of the HSCA 2008 (regulated Activities) Regulations 2010.

Regulation 9 9(1)(b)(i)(ii) Care and welfare of people who use services

How the regulation was not being met:

The provider had not taken proper steps to ensure that people using the service were protected against the risks of receiving unsafe or inappropriate care by means of the planning and delivery of care and, where appropriate, treatment in such a way as to:

- Meet the service users individual needs,
- ensure the welfare and safety of the service user..

Our findings

Planning and delivering evidence based care and treatment

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

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

The Trusts had removed the use of the Liverpool Care Pathway and implemented interim guidance called "Caring for people in the last days and hours of life." Training concerning the replacement was still being undertaken by the Trust and not all of the staff we spoke to were aware of the new paperwork in use.

In the end of life service, staff followed guidance set by The Gold Standards Framework (GSF). This was a way of working that had been adopted by patients and all the health care professionals involved in their care. We saw staff working together as a team and with other professionals to help to provide the highest standard of end of life care possible for patients and their families.

Alder Ward at Norwich Community Hospital was dedicated to providing stroke care. There was multi-disciplinary working in place and patients received support from nursing staff and a range therapists. Staff were familiar with the NICE (National Institute for Health and Care Excellence) guidance on stroke rehabilitation and they adhered to this.

Staff in the community dental service had undertaken an audit to monitor performance. The audit looked at the referrals received to identify if the service was being used

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appropriately. Treatment was in line with national guidance, for example National Institute for Health and Care Excellence (NICE), British dental Association (BDA) and General Dental Council (GDC).

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

We found that care records and handover records contained a significant amount of information about patients but these were not always being used to generate care plans in the inpatient areas. Care plans were core with some space for personalisation to the patient's needs. We saw that these were mostly incomplete and just had a patient's name label on the top of each sheet. The lack of a meaningful plan of care with details of the patient's needs meant that staff would need to read the whole file to extract relevant information about the patient's care needs. From reading the information in care plans and talking with staff, there was a sense that they were not valued by staff. We spoke with a ward sister who told us the care plans were just another form filling exercise that they did not have time to do properly. We found in many of the care records we looked at the care plans did not describe how staff were to meet the patient's needs. For example we saw one patient with a potential infection without a care plan in place to detail how this patient should be cared for. Another patient had a pressure ulcer but it was not recorded what dressings were required or what frequency the dressing required changing. This patient did not have a pressure ulcer prevention management plan. We saw another patient who did not have a personal hygiene plan in place. Conversely, most of the night care plans we saw did contain some personalisation regarding the patient's preferred routines. We did note the care plans for patients at Ogden Court were personalised.

There was an online system in place for pathology laboratories to report back on test results. Locum doctors told us they did not have access to this system so there were some delay in results being received as they had to telephone for results. Staff we spoke with were not clear as to whether this was going to be addressed.

Children and young people's needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence-based guidance. For example, the Trust had a family nurse partnership (FNP). The FNP is a voluntary health visiting programme underpinned by internationally recognised evidence based guidelines for first time mothers.

Health visiting and school nursing teams aimed to work in accordance with the Healthy Child Programme. The Healthy Child Programme is an early intervention and prevention public health programme that offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. The Healthy Child Programme identifies key opportunities for undertaking developmental reviews that services should aim to perform.

All health visitors, therapists, clinicians and nurses we spoke with were aware of the guidelines relevant to their scope of practice and were working to support their success. We saw evidence of the Edinburgh Post Natal Depression Scoring Tool in use and evidence that relevant National Institute of Clinical Excellence (NICE) guidelines such as Enuresis and Childhood Obesity were worked with. The SALT team was observed to use evidence based practice such as the Nuffield Dyspraxia Programme and clear reference was made to the Early Support principals being implemented. Early Support is a way of working, underpinned by 10 principals that aim to improve the delivery of services for disabled children, young people and their families.

The children's service had reached UNICEF Baby Friendly Level 2 Accreditation. This meant The facility has created policies and procedures to support the implementation of the standards and these had been externally assessed by UNICEF UK to demonstrate that staff had been trained and the standards implemented. Plans were in place for the service to reach level 3 accreditation by March 2015. This was also supported by an agreed CQUIN (commissioning for quality and innovation indicator) for 2014/15.

Pain relief

Patients within end of life services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication', which was prescribed to manage any breakthrough pain. This is pain that occurs in between regular, planned pain relief. We saw that care followed the national Institute for Health and Care

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Excellence (NICE) Quality Standard CG140. This quality standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in palliative care of adults.

We observed a community nurse following the prescribed medicine protocol for pain relief and administering the medicines prescribed through a syringe pump. We noted a community matron promptly visited a patient when a call came through to the community centre where the nurses from the Coastal Integrated team (West locality) were based. A syringe pump had become blocked and the problem was resolved promptly.

One patient we spoke to at the day hospital demonstrated a good understanding of their pain medication, and told us the staff had explained everything very well. The patient's relative told us they thought their relative's pain was managed appropriately.

We talked to patients about how well they felt their pain was managed. Patients were positive about this. They told us that pain relief was offered and given immediately it was requested. For one patient we saw that there was no stock on the ward of a particular pain relieving medicine which they were prescribed. This meant that if the patient was in pain the medication prescribed was not available.

Dentists explained the benefits and use of local anaesthesia prior to its administration and ensured patients understood what effects they may experience. We observed time was given for localised anaesthesia to take effect prior to proceeding with treatment. Inhaled or intravenous pain relief was administered according to planned treatment that had been agreed with the patient. These types of pain relief were only used where the staff had the skills and facilities to ensure patient safety. Following treatment, dentists gave verbal advice about pain relief and provided information leaflets which included advice about pain relief.

Nutrition and hydration

The care records we reviewed showed staff supported and advised patients who were identified as being at nutritional risk. The two patients we spoke with confirmed that they had received advice and support from the dietician and were very happy with the food.

Across all of inpatient services we saw patients were screened for the risk of malnutrition on admission using the Malnutrition Universal Screening Tool (MUST). Where risks were identified the risk assessment included a section to describe the actions to be taken to reduce the risks. When patients were admitted their food intake was monitored for three days to assess if this was an area of concern. We saw where it was assessed necessary, fluid balance charts were kept to monitor patient's fluid intake and output. The completed ones we saw indicated that patients were offered fluids regularly and the charts were totalled up at the end of each day to monitor the level of intake/output. We observed a routine review of a patients care plans in the community which had included a risk assessment using the Malnutrition Universal Screening Tool (MUST) score. The community nurse demonstrated how the MUST tool was used to assess the patient's nutritional needs. The nurse told us if they had concerns about a patient's nutritional and hydration needs the patient would be referred to a dietician or speech and language therapist via their GP.

All wards operated a protected mealtime where staff and visitors gave patients the space and time to eat. This did not preclude relatives visiting who had a role in supporting their family to eat and we did see relatives who were continuing in this role. The Trust provided cook/chill meals which were delivered to wards every few days. These were heated at ward level. We observed good stocks of food and snacks on all wards. Staff told us they had adequate stocks of foods and snacks and they could easily request special diets if they were needed.

A 'red tray' system was in use to alert staff that patients may be nutritionally at risk. Most patients were supported well at mealtimes, however we observed one patient with a red tray who received little support from staff and noted that they ate very little. We saw plate guards, large handled and angled cutlery available to enable patients to eat independently.

Most wards had photographs of the foods that were served to help patients make a choice. As food is largely a personal choice we received a variety of comments on the quality and choice of foods. Some patients told us that the choice of meal offered was limited if they were one of the last patients to be asked. On one ward patients in the bays told us the choice offered was frequently limited as patients in the dining room were asked what they would like first. The majority of patients we spoke were positive about the foods served.

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We accompanied a community nurse who was visiting patients who suffered from diabetes. The patients required insulin injections before they had their meals. In the course of these visits the community nurse prompted each patient to maintain a healthy diet. During another home visit, we observed an occupational therapist asking a new patient if they were eating and drinking well. The therapist advised the patient and gave a booklet on hydration and nutrition.

Approach to monitoring quality and people's outcomes

Every year the Trust set a number of quality goals. The Trust reported on its achievement of the 2013/14 quality goals. For example, the Trust stated is had achieved:

- Development of mortality review panel - Monthly review meetings in place, proforma developed, Palliative care reviews, and standards that mortality will be reviewed against Development of End of Life care implementing new national guidance Board seminar provided on death and dying provided
- Essence of care - Reporting system of quarterly reporting agreed. A number of the 12 outcomes are already captured through clinical audit, patient safety thermometer and existing strategies e.g. reducing pressure ulcers **-** Essence of Care audits completed for: Pressure Ulcers and Privacy and Dignity.

This meant the Trust had made improvements to the quality of the service being delivered to patients.

Between January to March 2014, the Trust's bed occupancy was 86.5% compared to the England average of 87.4%. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.

We saw evidence that end of life services monitored the performance of their treatment and care. Data showed that between April and July 2014, there were 494 deaths of patients within the care of the community nursing and therapy teams. Of these 494, 266 had indicated their preferred place of care, and of these 245 (92%) died in this preferred place. This meant that for the majority of patients, services were being provided to meet people's individual wishes.

The National Bereavement Survey (VOICES) was conducted by the Office for National Statistics on behalf of the Department of Health. The aims of the survey were to assess the quality of care delivered in the last three months of life for adults who died in England and to assess variations in the quality of care delivered in different parts of the country and to different groups of patients. The survey results suggest that the Trust is at least in line with the national average in all areas and above average in terms of :

- GPs and hospital doctors providing excellent care,
- Sufficient help and support for family at time of death
- Involvement of families and patients in decisions.

Specific outcome measurement tools in children's services were not widely in use. When we asked this question across many of the teams there was an agreement that improvements were needed in the way that patient outcomes were evidenced. We read in the Trusts Quality Account that children's services used the East Kent Outcomes System to monitor patient outcomes. However this was not articulated by staff during our inspection.

The starfish team told us that they monitored patient progress through using a goal based assessment tool. We saw goal setting approaches being used across services during our inspection in order to focus and agree on outcomes with children, young people and their families.

Recent audits had been undertaken regarding post-operative care and referral processes within community dental services. Post-operative information for patients had been revised which had resulted in a reduction in the number of patients returning with post-operative complications. To improve referral processes the standard referral form had been revised. There were mixed responses from staff regarding its effectiveness. Some staff told us they received more patient information about patients referred for treatment as a result of the revised referral form. Other dentists reported the actual number of inappropriate referrals had not reduced as a consequence.

Staff undertook regular audits of clinical records and consent processes, the results of these were reported at monthly staff meetings to ensure shared learning and agree actions to improve standards of record keeping. Other previous audits had included the prescribing of antibiotics.

Adult community services monitored the quality of the service they were providing through a range of different

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audits. Audits on leg ulcer care, assessment of the safe use of insulin, the management of the diabetic foot as well as a Trust wide audit of record keeping and management were undertaken in the last 12 months.

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

The Trust had developed a mortality review policy which was approved by the Trust board in September 2014. We considered this to be an area of good practice for a community Trust. The aim of the policy was to have a consistent approach to review patient mortality across the Trust and to provide a clear reporting structure to escalate any concerns. All inpatient deaths were reviewed and included the cause of death, the length of admission, the categorisation of death and any concerns were noted. Further scrutiny was applied where concerns were identified and there was a clear process for escalation in place. The mortality review group was led by the Trusts medical director who provided strong leadership for the initiative.

Competent staff

The Trust recorded a compliance score of 87.1% for its mandatory training programmes in 2013/14 against a target of 90%. This meant that the majority of staff had undertaken the Trusts mandatory training programme. Staff spoke positively about the mandatory training programme which was delivered. In addition to the classroom based mandatory training some training was available as e-learning packages. Attendance at training was being affected by short staffing levels. On three wards during our visit staff told us that attendance at planned training had been cancelled as staffing levels were insufficient to allow them to be released.

We were told that following a successful implementation of a similar model in adult services, this year had seen the introduction of family-centric training ("Faye Milly"). This was block training and captured multiple items of mandatory training in one session and was specifically for children's services staff. However, staff did not get access to training such as infection control, medicines management, mental capacity and deprivation of liberty safeguards.

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

Staff that had recently gone through the induction programme were positive about it. Staff told us they were able to access professional training in line with their specialism. We spoke with a senior manager who was responsible for one of the localities and they showed us evidence that staff were able to undertake different programmes of non-mandatory study to enhance their practise. We saw they monitored this to ensure access to study was fair and equitable across all staff groups.

Staff's experience of clinical supervision was variable across teams and some staff were not accessing regular protected time for facilitated in-depth clinical supervision. Clinical supervision is a way of supporting staff in the development of their practice. The director of nursing told us they were aware that clinical supervision was patchy, particularly amongst nurses. Initiatives were in place to try and improve access to supervision such as group supervision being available. All therapists told us they received regular clinical supervision regarding their practice and the director of nursing reinforced this and told us that uptake of supervision amongst therapists was very good.

Most staff we spoke with told us they had had an appraisal within the last 12 months and staff thought it was a supportive and valuable process. Records showed that the Trust's appraisal rate dropped below 90% to 66.6% in May 2014. The North locality had the highest level of compliance with a rate of 74.8%, whilst the South locality had the lowest rate at 51.4%. The most recent information from September 2014 indicated that 67.43% of staff have completed performance development reviews in the past year. This meant there had been little progress made since May 2014.

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

The Trust provided over 400 training placements for student nurses and therapists across the organisation. One

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nurse told us they had only recently qualified but the Trust had support mechanisms in place to supervise and support them until they felt competent to work alone in the community.

The Trust employed 27 (17.63 whole time equivalent) doctors and confirmed all of these were compliant with revalidation. Dental staff were registered with the General Dental Council, (GDC). The GDC is an organisation which regulates dental professionals in the UK. We saw evidence that clinical staff participated in Continuing Professional Development (CPD) in line with their GDC requirements.

Use of equipment and facilities

Availability of equipment in the community was noted to be a particular issue. We heard from more than one member of staff who had bought their own equipment in order to support the children on their caseloads. We were told that there was not an adequate process in place to replace or buy new equipment which would assist a child during their treatment.

We observed dental equipment was used appropriately and for the purpose it was intended. The centres had modern treatment rooms and x ray facilities. We saw records of regular maintenance and servicing of specialist equipment by the manufacturer to ensure it was fit and safe for use. Staff said they had access to sufficient equipment to provide care and treatment.

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

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

Multidisciplinary working and co-ordination of care pathways

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.

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

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

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

In the end of life care service, staff told us there was effective communication and collaboration between teams who met regularly to identify patients requiring visits or to discuss any changes to the care of patients. The meetings followed the principles of the Gold Standards Framework. As a minimum the service held a full MDT reassessment of patients led by a named senior medic every three days. There were also ongoing daily reviews of all patients.

The service used an Electronic Palliative Care Coordination System to support the co-ordination of care so that people's choices about where they die, and the nature of the care and support they received was respected and achieved wherever possible. This enabled key medical information and conversations about end of life care wishes to be communicated across areas and with external providers and services.

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Communication and coordination between all the health care professionals within end of life services was enabled through the use of the electronic palliative care coordination system known as "Systm one." This was accessed by all the professionals who were caring for the patient including the District nurses, specialist nurses, Macmillan nurses, and some hospital services. It enabled staff to record and share information necessary to ensure the on-going needs of the patient, including decisions about their care, could be widely accessed.

Within the adult community integrated care team weekly meetings were held between the nursing staff, social services, the housing department, allied health professionals and members of the voluntary sector. This allowed the opportunity to discuss individual patients who had complex needs and were requiring end of life care.

We observed some staff handovers, these were effective and comprehensive in ensuring staff had information on patient's needs. Nursing staff described close working relationships with occupational and physiotherapists.

Staff worked in partnership with other specialists to ensure a patient focused service. For example, they liaised with gynaecological, ophthalmic and podiatric specialists regarding patients scheduled for treatment under General Anaesthetic (GA) to minimise the number of GA's a patient received. There was a general anaesthetic treatment pathway that meant the patient from referral to the dental practice for pre assessment to treatment under general anaesthetic at the local hospital was cared for by the same dentist.

We attended multiagency meetings within the children's service and found there was a good evidence based approach to how these meetings were conducted. They were clearly based around the needs of the child and clear outcomes were identified and agreed. The Trust ran a key worker service. This service was available to children and young people from birth to the age of 19 who had complex or high levels of needs and saw at least three specialist health care professionals from at least two other organisations. The role of the key worker was to be the point of contact of the families to ensure they could access all the support services they needs. They made sure all agencies worked together to meet the needs of the child, young person and their family.

We noted an excellent approach to the development of pathways within the school nursing team. We noted that practice was already based on NICE guidance but work had begun on the development of a suite of evidence based pathways for the team. There was a good use of skill mix in this development and we noted that other relevant expertise's (such as from the local acute hospital) had been sought.

Good

Are services caring?

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

Summary of findings

Throughout our inspection staff spoke with compassion, dignity and respect regarding the patients they cared for. We found all of the services we inspected to be providing compassionate care but it was outstanding in the community dental service.

In the children's service, staff were passionate about providing care centred on the needs of children, young people and their families and recognised the importance of engaging with families in order to understand their situation and the support they required.

Community end of life, inpatient and adult community services were also delivering a compassionate service which also promoted patients privacy and dignity. We observed positive interactions between staff and patients in their homes and in every unit we inspected.

People were overwhelmingly positive about the care and treatment received in the community dental service. We found staff were committed to providing a specialised dental service for patients. Patients were given clear explanations during pre- assessment avoiding the use of technical terms and providing diagrams to enhance the patients understanding of planned treatment.

Our findings

Compassionate care

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

We observed positive interactions between staff and patients in their homes and in every unit we inspected Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. The patients we spoke with were very complimentary about staff attitude and engagement. One person told us they could not praise the staff more, they said that 'the staff in the day hospital are fantastic and very caring, they greet you with a hug and a kiss." Another patient and their relative told us, "The care here is fantastic."

We spoke with seven patients and six relatives. All were consistently positive about their experience within the end of life services.

We attended home visits during our inspection. We saw the community staff treated patients with compassion and cared for the patient as well as their family. Patients were appreciative of the care provided to them and were keen to praise staff. Patients told us the staff were dedicated and one person told us, "Nothings too much trouble for them." Another patient told us "Staff are very patient – I watch them with other patients they never get ruffled."

Patient's told us they would not hesitate to ask staff for help if they needed it. One patient told us that they considered the staff to be "Kind and compassionate." Another comment was that staff were "Caring and attentive." Another patient told us, "I have had very good care and been treated with respect."

We saw that staff provided patient-centred care. Staff encouraged the children and young people to make their own decisions. They had good knowledge of the backgrounds and preferences of the children and young people they were caring for. One parent described the staff as "..friendly and patient". A child that we spoke to told us that they would recommend the service to their friends and their only concern was that "Not all the bits are there in the peppa pig house."

Health visitors who we accompanied on visits all demonstrated a compassionate attitude towards the families and children they were caring for. There was clear understanding of people's individual circumstances and these staff members showed a skilful and sensitive approach to discussing areas such as a baby's welfare and a mother's mental health.

We were provided with compliments which had been received by the service. It was clear that many people had received care and treatment which met their expectations. For example, one person wrote "Thank you for doing so much more than your job. Your advice and kind words will never be forgotten. Thank you for keeping my spirits high and my smile wide."

Good

Are services caring?

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In the community dental service, patients and their relatives told us staff were patient and understanding. People spoke positively about the care and treatment received. One patient said, "I was so nervous I was housebound initially but over several appointments I have been able to have treatment.'' Another patient said, ''They are a very dedicated team.''

We observed good interactions between staff and patients. For example one dentist put people at their ease and chatted with patients recalling important events in their lives such as school exams, their favourite sports. One patient said, ''They talk with you first and chill you out, they give you time.''

We spoke with the parent of a child attending a pre-assessment appointment, they said, ''My child needs quite a bit of dental work and is terrified of the dentist but they have managed to gain her cooperation and been so patient with her.''

A relative during a community dentist domiciliary visit said, '' We only needed a little bit of help. It's so difficult for me to help my wife even go to the shops. I never expected this, it's wonderful. Look she doesn't even know the tooth has been removed, he (the dentist) is amazing." One patient who had experienced difficulties attending for treatment due to problems with their wheelchair had written to the staff to thank them for understanding their situation and helping them.

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

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

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

Dignity and respect

We saw staff regarded patients with dignity and respect and spoke to them in a courteous manner.

Where wards were short staffed, staff were observed to be cheerful and kindly to patients even though the interactions were brief and focussed on the care being provided. Most but not all staff wore name badges so patients were not always aware of the name of the staff member who was providing care to them.

In the inpatient areas we observed that all patients were cared for in same sex accommodation in order to safeguard patient's privacy and dignity and, to comply with the Government's requirement to eliminate mixed-sex accommodation.

We observed some handovers were held in closed rooms or offices, but some handovers and discussions were held at nurses' stations which meant patient's confidentiality could be breached. We did not see handovers taking place with the patients. On all wards there were rooms available to allow for private discussions and meetings.

We observed staff knocking on side rooms doors before entering, ensuring that patient's privacy was respected.

At Ogden Court a privacy film had been applied to some windows. This had been applied incorrectly meaning that patients could no longer see into the garden as the mirrored side was facing them. It also meant that people outside could see through the windows onto the ward without staff being aware of this. This meant patient's privacy was not protected.

We saw staff respected the children, young people and families they were caring for. We saw them give children time to answer questions and they all got down to the level of the child to establish and maintain communication. All of the communication we witnessed was appropriate and met the needs of the individual child being cared for. One child told us that the doctor they saw was "very nice".

Good

Are services caring?

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We undertook a visit to the home of a family with a child who had complex needs. We found the staff member demonstrated dignified and delicate care. They were supportive and empowering and able to rapidly build Trust with the child.

We observed patient interactions on our visits to the children's residential respite units and again noted all interactions to be positive and appropriate. One parent reported that they felt the staff were "Very attentive."

Within the dental service, we observed people were consulted at each stage of treatment to ensure they had their permission to proceed and that people were given reassurance before continuing. For example, one person we spoke with had a phobia of dental treatment and told us he would gag the moment an examination commenced.

We observed the dentists ensured when discussing treatment options with people they maintained eye contact. The staff were familiar with the person's fears and took time to reassure and relax the patient without the need to use medication. People were greeted in a friendly and courteous manner and reception staff were discreet to ensure patient confidentiality when booking appointments for patients in the reception area or by telephone. During treatment doors were kept closed to ensure privacy.

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

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

In the end of life care service we saw the nurses treated the patients respectfully and with dignity, they were welcoming towards the patient and their relatives and supported them in a professional and sensitive manner. At Priscilla Bacon Lodge we observed staff speaking to patients in a caring and respectful manner during patient contact. We observed staff were smiling and positive. Staff took time with each individual patient and would make equal eye contact by ensuring they were at the same level as the patient so as not to stand over them.

The National Bereavement Survey (VOICES) was conducted by the Office for National Statistics on behalf of the Department of Health. The aims of the survey were to assess the quality of care delivered in the last three months of life for adults who died in England and to assess variations in the quality of care delivered in different parts of the country and to different groups of patients. The survey results suggest that the Trust was average in terms of dignity and respect

Patient understanding and involvement

On some wards we saw goal setting which took into account what patients wanted to achieve. However, these were not always incorporated into the patients care plans and were kept separately. This meant the reviews of care plans did not necessarily take into account the patient's goals.

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

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

Good

Are services caring?

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

We spoke with six relatives and three patients both during and following our inspection. They all told us they had been fully involved in the care provided and had a clear understanding of what was happening at all times.

We observed many patient interactions during our inspection and noted that the staff were empathetic and that they listened to what they were being told. We noted appropriate responses and interventions. Treatment goals and next steps were discussed and agreed with both the child and their family member or representative.

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

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

Emotional support

The specialist palliative care team supported people emotionally. All the patients and relatives we spoke with valued the support offered by the nursing teams. The team had received training to enable them to support patients and families; they also delivered training to community staff. Bereavement counselling was also available through the Trust Psychological service. The service helped patients who were either living with a life-limiting illness or were at the end-of-life . Support was also available to patients families. We noted that this service was available for families for up to a year after bereavement has occurred.

During a home visit with the community nurse, we met a specialist nurse from the palliative care team who had been asked by a GP to visit the patient to give support to their partner, who seemed overwhelmed when the patient had been discharged home a few days earlier. We observed staff speaking to patients in a kind manner. On Beech ward staff were aware of how having a stroke impacted on patients' emotional well-being. As a ward specialising in stroke rehabilitation, groups were held to support patients with the psychological impact of stroke. The chaplaincy staff visited all wards regularly to offer spiritual support to patients. Staff considered the chaplains to be part of the ward team and were positive about their contribution to patient's care.

Children, young people and their families received support to cope emotionally with their treatment and care. We found all the staff we spoke with were child and family focused and they considered the family unit when completing their assessments. In most cases it was clear that staff worked with families as well as the children and young people. We noted on numerous occasions staff awareness of the emotional needs of the people they met with. Advice and guidance was offered and where appropriate information relating to support services was offered.

We also spoke to the parent of one child who had received advice and guidance from the children's centre to arrange housing and benefits. This person was grateful for this service going "Above and beyond." This was also demonstrated to us with conversations with other professionals who all said they would provide information and advice about how people could seek support with matters such as access to mental health services, education or financial support.

We observed the dentists asked patients if they would like their relative or carer to accompany them in the treatment room. At one clinic the dentist positioned the parent of a child receiving treatment and checked the child was able to see their parent throughout their treatment. When local anaesthesia was administered the dental nurse held patients hand and gave reassurance and praise.

There were pictorial care pathways provided for children who had been assessed as requiring general anaesthetic. This was provided to help them understand what to expect and minimise their fears about planned treatment. Children showed to us they had received stickers after treatment as a reward for being a good patient.

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

Promotion of self-care

Therapists generally provided very detailed assessments of patient's abilities to care for themselves. We could see that

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self-care was promoted to improve patient's independence but there was a lack of personalisation in care plans. This meant staff might not always be clear about what each patient could do for themselves.

At Swafham Hospital there was an activities coordinator. Not all wards/hospital had an activities coordinator but there were some activities were held to promote socialisation, dexterity and psychological well-being. The range of activities varied according to staff availability.

One patient told us they were encouraged and supported by staff to help themselves to dress following a shower. Another patient told us the physiotherapist had taught them a way to get themselves out of the chair and they had started to be able to take themselves to the toilet. Following a therapist assessment, a person commented, "I am so pleased with the way the staff explained things to me. I feel more confident in doing things for myself and have learnt how to stop myself from falling again. The therapist is very good and I am very pleased the therapist is coming back next week to see me."

Due to the complex needs of patients receiving end of life care services, it was not always possible to promote self-care. However, the patient records we looked at included person-centred care plans based on the individual needs and preferences of patients. 92% of patients died in their preferred place of care.

Where possible children and their families were supported to manage their own treatment and care needs.

For example, goals were discussed and agreed and families were given advice and guidance about how they could progress with treatments alone.

We saw that educational classes were provided for parents so that they could gain a better understanding of their child's needs. For example, one parent told us that they had attended an introduction to autism class and we also heard about the Norfolk Steps Programme which was available to parents and which this service promoted. This training programme was in place for parents of children aged 4-18 years who have special and additional needs and whose behaviours are physically challenging.

The dental service employed three oral health educators. We saw recent correspondence from children displayed in the reception area describing what they had learnt about caring for their teeth.

During appointments the dentists asked questions about each patient's current oral hygiene practice and gave suggestions how this could be improved to prevent problems. Where a patient's carer attended an appointment with the patient they ensured the carer was involved in the discussion. People who had received treatment were given explanations about what to do to minimise discomfort and prevent problems such as having saline mouthwashes following dental extractions. The dental nurses ensured patients also received written information about how to care for their teeth after treatment and between appointments. The staff went through the information to ensure they understood it.

Are services responsive to people's needs?

Good

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

Summary of findings

We judged the responsiveness of the services as good with the exception of the adult community service which we judged as requiring improvement.

We saw that leaflets on how to make a complaint and contact PALS were available on wards and in reception areas. The Trust also kept a record of all compliments received. Over a thousand compliments were recorded during 2013/14. Staff told us there was active reflective practice and learning following complaints.

Aspects of the ward environments were dementia friendly. Most inpatient wards had garden areas with seating where patients and their relatives could sit outside. We noted that the wards at Norwich Community hospital did not have this space available.

Therapy staff did not work weekends but healthcare assistants had received training to work on exercises with patients. Staff told us that some patients were admitted to the inpatient wards late at night. The reasons for late were generally outside the Trust's control but it did affect patient care.

The service planned and delivered care to meet the needs of children, young people and families. We saw good examples of how services had developed based on the feedback of patients which included extended service opening times. Health visiting teams did not work flexibly and this was resulting in resources being wasted because patients were not attending appointments.

We were concerned about arrangements in place to support children transitioning into adult services. There was no pathway in place and some staff were unsure of what services could be accessed when children left their care.

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

The Trust monitored the responsiveness of its services and monthly reports were provided to the Trust board. The access to services scores were higher than the Trusts targets. This meant the majority of patients were getting a responsive service. The Trust achieved the 18 week referral to treatment target (RTT) with performance of 98% in July 2014. Musculo skeletal (MSK) physiotherapy, podiatry surgery and specialist nurses epilepsy management were not meeting the 18 week referral to treatment time.

Our findings

Service planning and delivery to meet the needs of different people

The Trusts palliative care service provided care for 652 patients during 2013/14. We found the service had a good understanding of the different needs of people it served. Services were planned, designed and delivered to meet those needs. There was evidence that staff actively engaged with local commissioners of services, the local authority, other providers, GP's and patients to co-ordinate and integrate pathways of care that met the health needs of patients. Service specifications were in place which detailed the aims, objectives and expected outcomes for patients nearing the end of their life and were monitored against national and local performance indicators. Outcomes showed patients were receiving a high quality service.

There were referral criteria in place and there were discussions about all patients who were referred to the end of life care service, including those who were waiting for a bed.

Staff showed us leaflets about "Preferred priorities for care" that were given to patients. These provided simple explanations about advance care planning and the different options available to patients. We visited two patients in their own home and saw the patients had received this leaflet.

There were identified link nurses who worked with the local prisons to provide end of life care support to the prison population.

At Priscilla Bacon Lodge we saw complimentary therapies such as reflexology and massage were offered.

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Car parking was available at all of the hospital sites including designated disabled parking bays. Parking was free at all hospitals apart from Norwich Community Hospital. We saw there was clear signage on all wards to help patients orientate themselves around.

Staff knew how to access interpreting services but told us they could not recall ever having to use them. We did not observe any patients on the wards at the time of our inspection that needed an interpreter.

Aspects of the environment in the inpatient wards were dementia friendly, this included having blue toilet seats in place and we noted there was clear signage. Some wards had sensor activated lights which came on automatically, limiting the risk of accidents in dark rooms.

Visiting hours were displayed on each ward as well as on the Trust's website. Ward managers told us visiting hours were flexible according to family circumstances and how seriously ill the patient was. Some wards had flowers by patient's bedside but others did not. Staff told us it was down to the individual wards as to which policy was adopted. Should a patient have an allergy flowers would not be allowed on wards at any time.

Most wards had garden areas with seating where patients and their relatives could sit outside. We noted that the wards at Norwich Community hospital did not have this space available. Staff told us they had asked if it was possible to develop a garden area and the possibility of this was being explored. At the time of the inspection staff told us there was no timescale for when this would happen.

We saw evidence that local communities valued their local community hospitals. All the hospitals we visited all had active 'Friends' organisations which supported them.

During our inspection we saw that translation services were available. We spoke with the parent of a child whose first language was Lithuanian. They told us that they were always provided with an interpreter when they came for appointments. We saw and spoke with the interpreter who had attended for this appointment. During our observations and conversations with staff there was a clear understanding of the availability of this service and how it could be accessed although we did speak with some staff who were less clear about the availability of interpreters and how they would be utilised.

We heard of various initiatives that had been developed in order to meet the needs of people. This included extended service times in child psychology services. We were told that this change was based directly on patient feedback. Some services had initiated a text messaging reminder service for appointments which had received positive feedback. We noted that not all teams were using these initiatives and some services, such as health visiting might have benefited from using them.

We found limited flexibility within the health visiting teams in order to address the current capacity issues. We found that out of hours or flexible working was not being routinely implemented as way of improving the services outstanding developmental checks. We were told that some staff had raised this is a potential way of working however this had not been taken up because there would be no staff member who was office based to offer out of hours support. We were concerned about how the service was being flexible around appointments that had been cancelled. For example, we spent time with a health visitor who only saw one patient in a day because many appointments were not attended. This meant valuable health visiting time was being wasted. Health visitors were aware that many patients requested evening or weekend visits, yet the service was not able to be flexible to meet those needs.

In one area we saw that as a solution to some of the difficulties, the children's centre team had assisted by developing two year developmental review clinics. These clinics were designed to free up health visitors time by allocating one health visitor supported by family support workers to a three hour clinic to see multiple children. This was a good initiative and the parents we spoke with at these clinics were supportive of it. But, again, we noted that many appointments were not attended. This meant that they would need to be re-allocated. We asked how the effectiveness of this service was being monitored and we were told no review had been undertaken.

The clinics we visited were generally well maintained and decorated in a suitable manner to meet the needs of children. The reception area of Upton Road was fairly bland, however there were a number of posters aimed at parents, containing information about activities happening in the area, for a range of children. There was access to refreshments and child friendly toilet facilities. We did note there were no low chairs for children to sit on.

Are services responsive to people's needs?

Good

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People were referred to the community dental service who had been assessed as having complex or special needs, including learning difficulties, where treatment with a general dental practitioner was not possible. The service also met the needs of children under 16 years of age with behavioural or management problems which made them unsuitable for treatment within general dental services. Staff reported most patients were seen within six to eight weeks from referral. Staff anticipated this waiting time would improve when new staff recently recruited had commenced.

The service worked collaboratively with other services such as general dental practitioners, social workers and hospital teams. Dentists and surgeons worked collaboratively, for example for those patients whose medical condition necessitated dental care being undertaken in a hospital setting. This meant patients received care in the environment that could safely meet their needs. Appointments were timed to allow people with more complex needs the time they needed.

The dental service provided a domiciliary (home visiting) service for people who were not able to attend the clinic due to illness or disability. The relative of one patient we visited said, I don't know how we would have managed without this visit it's so difficult to get out, they (the staff) are wonderful."

Access to the right care at the right time

We saw through advance care planning, patients were able to dictate both their preferred place of care and preferred place of death. Information received prior to our inspection showed that the Trust monitored the performance of their end of life treatment and care service.

Data showed that between April and July 2014, there were 494 deaths of patients within the care of the community nursing and therapy teams. Of these 494, 266 had indicated their preferred place of care. Of these, 245 died in their preferred place of care which equated to 92%. Staff also told us patients were able to change their mind about their preferred place of care and preferred place of death and the electronic care records would be updated to reflect this change.

Patients were usually admitted to inpatient services from either nearby acute hospitals, from their own homes or residential care settings, usually referred by their GP or a community matron. The inpatient services provided by the Trust were not evenly distributed across the County. This meant that hospitals were not always near to patient's homes but people were given a choice regarding accepting admission.

There were Trust staff working in the local acute hospitals who assessed if patients met the admission criteria for the community hospitals. Relevant information on their condition as well as medication administration records arrived with patients when they were admitted to the community hospital. This meant staff had information about patients' needs on admission.

Ward managers told us they tried to keep a patients bed for 24 hours if the patient had to be readmitted back to the acute hospital following deterioration in their condition. Staff told us that some patients were admitted late at night, usually where they were coming from acute hospitals. The reasons for late admissions were attributed mainly to the availability of ambulances. Whilst this was outside the Trust's control, it did affect patient care. One patient told us they found the journey frightening due to the remote area. Staff told us that late admissions could be disorienting for patients. Medical staff did not work evenings or nights so late admissions would not see any medical staff to the following day. If a patient was admitted on a Friday evening they would not see the ward medical staff until the following Monday. The out of hours GP service could be requested to review patients who became unwell and needed a medical review out of hours. Medical emergency cover was accessed through the 999 emergency service.

Therapy staff did not work weekends. To ensure that patient's rehabilitation continued a number of healthcare assistant had been trained to work on exercises with patients and promote their recovery

The occupational therapy team raised concerns with us with regards to the current service specification. We were told that a historical decision was made to refuse referrals from new patients who were aged between 8 and 9. This had resulted in 18 patients being refused treatment in the past 15 months. We were told that this had impacted on patient complaints and the access to treatment for these children. We were told that this had been raised for commissioners to review but feedback had not been forthcoming.

Concerns were raised about the way the service for children with Autistic Spectrum Disorders (ASD) was commissioned.

Are services responsive to people's needs?

Good

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Children with a sole diagnosis of ASD did not receive any follow up treatment but if the child had an additional diagnosed disability as well as ASD they would receive ongoing care and treatment. The commissioners recognised the pathway for these children was not appropriate and it was currently being reviewed by a range of partner organisations.

We were told that the SLT team were not able to see patients requiring follow up appointments in a timely way. We were told that this was because follow up appointments were often cancelled so that new referrals could be seen in order to meet the services waiting time targets.

We noted excellent practice within the Starfish Plus service. This service was able to respond to new patient referrals on the day of receipt and ample time was allocated for visits. The caseload of the practitioner that we met with was 7-8 children. This enabled the service to offer 3 to 5 visits per family per week.

The community team provided a number of specialist services to meet the needs of the local community. They cared for patients suffering from stroke and epilepsy, neurological patients and people with long term conditions, as well as frail elderly people prone to falls and patients at the end of life.

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

We saw a patient who had suffered a stroke whilst out of the county. Because the patient did not enter into the stroke pathway at the time of diagnosis they experienced delays getting rehabilitation following their return home to Norfolk. Staff told us it was more difficult for patients to access the stroke pathway if they didn't start in it. This meant services were not equitable because it depended on where the patient suffered their stroke. The pathway was owned by another NHS acute Trust so this was outside of the Trusts control. We will raise this with the commissioners of the service.

The Trust monitored the responsiveness of the adult community service and monthly reports were provided to the Trust board regarding the number of patients with immediate health care needs seen within 4 hours of referral (category A), the percentage of patients with urgent care needs seen within 24 hours of referral (category B) and the percentage of patients with routine care needs seen within 10 calendar days of referral (category C). The results for this were good with 98% of patients being seen for category A, 92.3% for category B and 95.7% for category C. The access scores were higher than the Trusts targets. This meant the vast majority of patients were getting a responsive service.

In some areas people were able to access care and treatment promptly once a referral was made. This was demonstrated in the Coastal Integrated team (Hersham & Hunstanton area, West locality) where there was no waiting list. For example, a referral came through on 18 September 2014 from a local NHS acute Trust for a home visit. The patients required an injection on 14 October 2014. A named nurse was allocated online and scheduled the same morning. The waiting time for appointments in the Leg Ulcer clinic (Dereham, South Locality) were between one to two weeks. There was one patient on the waiting list at the time of our inspection. However, there were issues with waiting times for appointments for some outpatients' and specialist clinics due to inadequate staffing numbers, unfilled vacancies and increased demands and workloads as in the following services:

- Community Neurology Service/Clinic, St James Clinic, Kings Lynn (West Locality)

Are services responsive to people's needs?

Good

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The neurological team based at St James Clinic, Kings Lynn consisted of 16 staff of different disciplines, including specialist nurses, therapists and psychologists. The staff conducted mainly home visits and some clinics. Due to sickness the team was short of one full time physiotherapist and bank staff had been deployed but they were not always available. We were told the waiting times to see a physiotherapist or an occupational therapist were 7 weeks for urgent cases and 17 weeks for non-urgent cases. At the time of our inspection, there were 67 patients on the waiting list.

There was a long waiting list for patients suffering from stroke to see a therapist in the SALT clinic, namely 8-20 weeks, for a swallowing assessment and 30 weeks in the case of a communication assessment. We were told a business case had been submitted recently to the Clinical Commissioning Group (CCG) for an increase in SALT numbers to cope with the demand.

- Neurology Service/Clinic (South Locality)

The Neurology Clinic in Wymondham Health Centre (South locality) was managed by two specialist neurology nurses, supported by the hospital consultant and four GPs. Patients and GPs were complimentary about the staff and the service they managed. However, the specialist nurses had large caseloads totalling 880 patients and the waiting time had increased from 6 months to 8 months for patients to be reviewed. The initial referral was 6 to 8 weeks.

- Family Planning Service/Clinic (West Locality)

The family planning service based at St James clinic, Kings Lynn, had a two month waiting time for the insertion of a coil and three to four weeks waiting time for an implant.

- Continence Clinics

In the Norwich area the Continence clinic had over60 patients on their waiting list.

- Blood Clinic

The Blood Clinic based at Norwich Community Hospital was managed by two phlebotomists. We were told the waiting time for blood tests was around 45 minutes. Two patients told us they thought the waiting times in the blood clinic were too long and they felt the opening times were limited. The clinic was open until 14:00 hours. We observed three patients arrive at Norwich Hospital shortly after 14:00hrs for blood tests and were told the clinic was closed. They said their GP practice had not told them the clinic was only available until 14:00hrs.

- Podiatry Service (Norwich and West Locality)

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

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

- Musculoskeletal (MSK) Physiotherapy, 94.7%
- Podiatry surgery 80.4%
- Specialist nurses epilepsy management 98.4%

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

Discharge, referral and transition arrangements

The Trust told us that during 2013/14, there were 21 palliative care patients on inpatient units who had a delayed transfer of care to other settings. Of these 21 patients, four died on the ward, 4 died on the ward, 2 were transferred to another NHS provider and the remaining 15

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Good

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were transferred to their usual place of residence or a care home. This meant that 3.2% of patients had some part of their care delayed due to waiting to be discharged into another setting. The Trust were actively trying to reduce this further. In the inpatient service on the last Thursday of each month a snapshot was taken of patients whose transfer of care had been delayed. Between October 2013 & March 2014 there were 60 delayed transfers of care which was an average of 10 per month for non-medical reasons. However the overall trend had been decreasing over the year with a rate of just 5.0% compared to the upper ceiling of 5.4%.

Since April 2014, there was a single point of referral in place for the school nursing team. We saw how this system ensured the effective deployment of staff which enabled higher risk referrals to be fast-tracked so that children and families had access to care in a timely manner. We considered this to be an area of good practice.

Each of the health visiting teams held a weekly allocation meeting to discuss caseloads and allocate new referrals to the right staff members. We observed one allocation meeting and saw how consideration was given to the skills of each member of staff so they could meet the needs of the people accessing the service. Consideration was also given to existing patients and referrals to other services were discussed and agreed upon.

We were not assured there were sufficient pathways in place to support the transition of the children they cared for into adult services. We heard on some occasions that staff were not aware of adult services which could be accessed for children who would need on-going support into adulthood. The only exception to this was within the residential respite units where a clear pathway was in place.

Staff explained patients were reviewed at the end of a course of treatment before being discharged back to general dental services. On completion of treatment patients were discharged into the care of general dentistry unless the severity or complexity of their condition required their on-going care to continue within the specialised service. Where patients continued to meet the acceptance criteria for the specialised service they were advised recall appointments would be offered at appropriate intervals in accordance with National Institute of Clinical Excellence (NICE) guidelines.

A 'Silver Call' daily multi-agency discharge planning telecom had been introduced in the West Locality. This promoted patient discharges at the earliest stage possible and aimed to alleviate any barriers to discharges taking place. The manager told us that the length of stay figures indicated this was being successful in getting patients home quicker than previously. We considered this to be good practice.

Some wards had discharge coordinators but others did not. Where coordinators were in post staff reported this worked well and improved the communication and planning with other agencies who were involved in the patients discharge plan. There were no plans in place to extend the discharge coordinators role. On Beech Ward there was an Early Supported Discharge team in place. Staff told us this was effective in ensuring there was throughput on the ward.

Responding to and learning from complaints and concerns

We found information about the Trusts complaints procedure in all areas that we attended. Staff were clear about their responsibilities and were able to describe the process for escalating concerns internally.

We saw that leaflets on how to make a complaint and contact PALS were available on inpatient wards and in reception areas. The leaflet included the timescale in which a response would be given and was available in an easy read version as well as a range of languages. The Trust had a process in place for dealing with complaints which involved the production of a monthly complaints report. The report identified trends in complaints and the learning to come out of them. This was reported every month to the Quality Risk and Assurance Committee and to the Trust board.

The Trust reported 119 complaints received during the reporting period of December 2013 to May 2014, all of which were acknowledged within 3 days and responded to within 25 days. There were 19 complaints received about community hospital services in 2012 – 2013, this was exactly the same as the previous year. In some patient records, we saw that complaints were positively resolved at a local level at the earliest opportunity. These were not included on the complaints log, which meant there was a missed opportunity to learn from issues raised by patients.

Are services responsive to people's needs?

Good

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If patients left negative comments on the Trust's website responses were provided encouraging patients to contact PALS (Patient Advice and Liaison Service). The Trust also kept a record of all compliments received. Over a thousand compliments were recorded during 2013/14.

We saw numerous letters and cards expressing positive feedback from patients and relatives about end of life care. Staff were aware of the Trust's policy for handling complaints and had received training in this area. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at service level or through the Trusts Patient Advice and Liaison Service.

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

We looked at the response to two complainants that were chosen at random. Both the responses were signed personally by the Trusts chief executive and contained an apology that they had cause to complain. The responses were sensitive and answered the questions that were asked within the complaint. Where possible the complaints team would meet with the complainant. The team would also ascertain what outcome the complainant was looking for.

Are services well-led?

Good

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 of findings

Instructions

We identified some concerns regarding the leadership in services but overall we judged this to be good. The leadership within the adult inpatient areas required improvement.

There was a Trust wide Quality Improvement Strategy in place which set out the vision and approach to quality for 1014-2016. In addition there was also an Organisational Development Strategy in place that was developed from engagement of staff. The Trust had been through a transformation programme for community services and staff told us they had been involved in the consultation.

There was an effective governance system in place which was made up of a number of committees that reported through the Trust board.

The Trust board received a monthly Integrated Performance Report which rated key risks for the organisation.

Local risk registers were maintained but we found some risks were not reviewed in a timely manner and had been on the register for some time. The number of risks on the individual registers varied considerably, with the West locality having 30 risks and the specialist services unit having 258. The Trust took part in a planned Internal Audit review of the board assurance framework and risk management controls during September 2014. The review identified there were no risks in the systems and processes for risk management, but there were seven risks relating to the operating effectiveness of the systems and processes. Of these seven risks, five related to the management of the risk registers and two to the management of clinical incidents, serious incidents requiring investigation and quality issue reports. The Trust were in the process of addressing the areas identified by the internal audit.

There were four risks on the board assurance framework that were still rated as high risk after mitigation measures had been put in place. These related to safe staffing levels, effectively managing staff through change, dealing with cost pressures and not being able to deliver cost improvements.

The Trust was an integrated provider of health and social care working with Norfolk County Council. Section 75 agreements were in place and the Trust worked with Norfolk County Council to provide an integrated learning disability service. Work was under way to create a joint management structure with Norfolk County Council This meant there would be two executive positions, a director of Integrated Care and a Director of Nursing Quality. The post holders would take responsibility for all health and social care (excluding children's services) across the whole of the Norfolk's health and social care system. It will see the integration of community nursing, therapy and social work.

Our findings

Instructions

Vision and strategy for this service

There was a Trust wide Quality Improvement Strategy in place which set out the Trusts vision and approach to quality for 1014-2016. The Trusts vision was to improve the quality of people's lives, in their homes and community by providing the best in integrated health and social care. There were a number of strategic objectives in place which outlined how the Trust would improve quality, enable its people and secure its future. There were business plans in place for each of the services within the Trust.

There was an Organisational Development Strategy in place that was developed from engagement of staff across the Trust . As part of this work the Trust values were refreshed involving 900 staff members. They were formally signed off at an extraordinary Board on in June 2014. The values were in the process of being rolled out across the Trust through promotion materials, training at Induction, mandatory training and leadership training. We found some staff knew about the values but it did vary across the Trust.

There was good leadership and support from local managers throughout the Trust and most staff felt engaged with senior management. Staff felt leadership models

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encouraged supportive relationships as well as compassion towards people who used the service. Staff were encouraged to raise problems and concerns about patient care without fear of being discriminated against.

The children's community service was about to undergo a change in structure moving to a new integrated health and social care model. The changes had recently been consulted on and staff had been given opportunities to understand the proposed changes and provide feedback. All of the staff we spoke with were familiar with the changes and understood how they affected them.

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

Governance, risk management and quality measurement

There was an effective governance system in place which was made up of a number of committees that reported through the Trust board. The Trust Quality and Risk Assurance Committee (QRAC) reported directly to the Trust board. This committee was chaired by a non-executive director who had a good understanding of the Trusts governance processes.

There was a Board Assurance Framework in place (BAF). The BAF described how the Trusts governance processes worked and how the Trust board received assurance and identified key risks and their mitigating actions to manage them. A monthly risk group chaired by the Director of Nursing with representation from all of the business units/ directorates was in place. The group reviewed all risks on the corporate risk register and agreed what needed to be escalated to the executive directors for consideration for the board assurance framework. Local risk registers were maintained but we found some risks were not reviewed in a timely manner and had been on the register for some time. There were around 750 risks on Datix in September 2014, these were divided by 14 directorates/business units. The number of risks on the individual registers varied considerably, with the West locality having 30 risks and the specialist services unit having 258. We noted the West locality had been proactive and had reviewed all of their risks.

The Trust took part in a planned Internal Audit review of the board assurance framework and risk management controls during September 2014. The review identified there were no risks in the systems and processes for risk management, but there were seven risks relating to the operating effectiveness of the systems and processes. Of these seven risks, five related to the management of the risk registers and two to the management of clinical incidents, serious incidents requiring investigation and quality issue reports. The Trust were already addressing the areas identified in the review at the time of our inspection and were making good progress against their action plan. This was an area the Trust would need to continue to strengthen over the coming months.

There were four risks on the board assurance framework that were still rated as high risk after mitigation measures had been put in place. These related to safe staffing levels, effectively managing staff through change, dealing with cost pressures and not being able to deliver cost improvements. The latter risk had a RAG rating of "25 catastrophic," and had not been reduced after mitigation measures. The risk was cited as "If cost improvement programme plans are not delivered over the five year planning period then the Trust will be unable to achieve the required surplus and liquidity levels."

The Trust used an Early Warning Trigger Tool (EWTT) as a method of identifying risks within teams and services. The tool assessed metrics such as staffing levels, wait times and management arrangements. The tool should be completed by all teams and when the score reached a defined threshold, enhanced scrutiny was put into place. Within the Trust, any team/service rated as red had to have an action plan in place of how risks will be mitigated against. In July 2014 there were 85 teams./services who submitted their EWTT self-assessment and they all had an action plan in place.

The Trust board received a monthly Integrated Performance Report which rated key risks regarding performance for the organisation. This meant the Trust board were aware of performance across the organisation

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and could scrutinise and challenge action taken in response to this. Performance data was collected for each team and each locality. This included the use of the NHS Safety Thermometer to support the provision of safe care.

Regular quality monitoring visits were undertaken within the service. These visits used the Care Quality Commission's essential standards of quality and safety as a framework. We noted that both positive feedback and areas for improvement were identified. We saw that local meetings took place and minutes of these demonstrated that the findings were discussed and solutions and actions for improvement were agreed. The findings from these monitoring visits were not always followed up and we found some areas requiring improvement had been identified but not addressed. For example, in the inpatient areas a medication audit had identified areas of improvement but we found significant gaps in medicines management. Trust

As an NHS body, Norfolk Community Health and Care NHS Trust used the Information Governance toolkit. In 2013/14 the provider was rated "Satisfactory" against Level 2.

The Trust recorded a compliance score of 87.1% for its mandatory training programmes in 2013/14 against a target of 90%. The overall appraisal rate had dropped below 90% to 66.6% in May 2014. The North locality had the highest level of compliance with a rate of 74.8%, whilst the South locality had the lowest rate at 51.4%. The Trust had a plan to improve performance against this. However, the vast majority of staff we spoke with told us they had received an appraisal.

The Trust's sickness absence rate for January – March 2014 was 4.33%, which was slightly lower than the figure of 4.57% for Community Health NHS Trusts nationwide for this period. The May integrated performance report states that as at May 2014 staff turnover was at 10.9% .

Leadership

We found the Trust to have good executive and non-executive leadership. It was evident from the board minutes that non-executive directors provided challenge and scrutiny. Executive directors reported they felt supported by the Trust non-executive directors. There had been changes in the chief executive which some staff reported felt was unsettling. A new chief executive was due to take up post in October 2014.

The Trust Chair provided strong leadership and we noted the non-executive director who chaired the Assurance and Quality Risk Committee had an excellent understanding of the issues the Trust faced. There was good leadership from the nursing and medical director but there was a recognition that the portfolio for the director of nursing and operations was too large although this was being addressed as part of the Trusts integration of community services.

Executive Directors in the Trust had a good understanding of the challenges and risks the Trust faced. They spoke with compassion and that they aimed to ensure the Trust provided the best possible care to the communities they served. Executive directors were visible and many staff commented they had seen the Director of Nursing visit wards, departments and community teams.

We spoke with a number of other agencies such as the local authority and the commissioners of the services prior to our inspection. We found without exception, all other agencies felt the Trust had good leadership, were open and transparent and were committed to providing patients with high quality care.

We looked at the NHS staff survey results for 2013 and saw that the percentage of staff reporting support from immediate managers was 3.69 which is average when compared with other Trusts. Staff reported a positive culture in the service. They reported good engagement and felt they were being listened to. Staff spoke positively about the service they provided for patients. The staff survey reflected this finding with the 73% of staff feeling satisfied with the quality of work and patient care they are able to deliver.

Staff told us they were encouraged to raise concerns about patient care and this was acted on. We found all the staff were dedicated and worked well as a team. Where managers had approached the board with concerns about short staffing levels they told us they had felt supported and wards had closed to protect patients from the possibility of poor care or harm.

We saw data that showed staff sickness levels were in line or lower than expected targets. The majority of staff told us morale was good but we noted that there were some staff groups that felt less engaged with the Trust. Managers were praised as being supportive and approachable.

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We found staff to be positive about their job but they were feeling the pressures of working in an NHS Trust with staffing difficulties. Several members of staff commented that team working was very good. Several staff told us they were proud of the service they worked in. One staff member told us the organisation it was a "Kindly organisation, where I can talk to managers, I have raised a concern with the Chief Executive and as a result improvements were made."

Ward managers told us they attended a monthly meeting with their peers. This was regarded as a useful and productive meeting which enabled staff to share ideas and examples of best practice. Regular team meetings were held on wards to allow staff to share their views.

Nursing leadership at ward level was variable. We found some ward leaders displayed strong clinical leadership while others did not always display the values and behaviours that would be expected of a nurse leader. The Trust did offer a leadership development programme and were supporting staff to attend this.

Senior nursing leadership, such as that provided by ward managers and above was good. Generally we found therapy staff to have strong clinical leadership.

Culture across the provider

All the staff we spoke with assured us they understood the Trust whistleblowing policy and told us they would feel comfortable using it if necessary. This suggested that the Trust had an 'open culture' in which staff could raise concerns without fear.

We held a focus group for all members of staff within the service. We noted that staff clearly supported each other and there was clear sense of team work and pulling together. Staff were keen to praise and acknowledge areas of good practice. There was also a demonstrable knowledge with regards to areas which did not work so well and which required improvement.

Staff we spoke with were proud of the service and were committed to ensuring patients received compassionate and high quality of care. During our inspection we observed this passion and commitment translated into the actual delivery of care. Patients we spoke with were keen to tell us how impressed they were by the service provided; in particular they mentioned the understanding and patience of staff to ensure their needs were met.

Staff told us they had opportunities to meet with their managers and team members. Staff said, they (the managers) were very supportive and listen to what we have to say. They described how they felt valued and supported to develop their skills to enhance the service provided. Staff explained one to one meetings at regular intervals were to be introduced and felt this was a useful innovation.

We saw the results of the Trusts staff survey for 2013. The results for indicators such as staff motivation, job satisfaction and ability to contribute towards improvements reflected the findings of our inspection to this service.

The Trust supported the Nursing Times Speak Out Safely campaign. The Trust had done this because they wanted every member of our staff to feel able to raise concerns about wrong doing or poor practice if they saw it and confident that their concerns will be addressed in a constructive way. There was a whistle blowing policy in place and staff were able to tell us about this.

Public and staff engagement

There were 140 comments on the Trust on the patient opinion website, with 128 of these being positive in nature. Of the negative reports, six were regarding staffing levels and waiting times, three were around staff attitude and three regarding poor care. The Trust reported they received over 1000 compliments from patients, friends and family during 2013/14.

The Trust monitored its performance in the management of complaints, this included the number of complaints as well as the trends and themes people complained about. 100% of complaints were responded within the Trusts 23 day target. We saw evidence of the Trust identifying learning points from complaints and cascaded these through to staff through the weekly message, through newsletters and to the locality clinical governance meetings.

Every month the Trust board heard about a patient's experience at the start of their board meeting. A patient or carer was supported by the Patient Experience and Involvement team to share their experiences of their care from the Trust and how this connected with other services they may have experienced. Patients and carers could

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directly tell the board about where care had been good and where improvements could be made. Actions arising were followed up by the Director of Nursing Quality and Operations.

Generally staff told us staff engagement was good although some staff in different areas felt they were not listened to. Generally, staff spoke positively about being able to raise concerns with their immediate managers and to make suggestions for improvements. The majority of staff felt there were good lines of communication from the wider Trust, we were told about the "weekly message" which was disseminated to staff on a Friday and delivered key messages such as updates to IT systems, new policies and procedures, success stories and opportunities for staff to be involved with.

The Trust held a Recognition of Excellence and Achievement in Community Health (REACH) ceremony on an annual basis. This was an awards ceremony to recognise the contribution of staff. In March 2014 the awards included some for staff working in inpatient areas including the specialist neurological rehabilitation inpatient service.

We were told of examples where staff, due to different reasons, were unable to continue in the role they were employed in. The Trust had worked with staff to redeploy and support them in new roles, in some circumstances creating roles which were beneficial to the patients care pathway.

The results of the 2013 NHS Staff Survey showed the Trust has performed better than the national average against five questions and worse than the national average against five questions. The Trust performed better against questions regarding staff feeling their role made a difference to patients, effective team working, staff receiving job-relevant training, staff being appraised and staff receiving health and safety training. The Trust performed worse than average against five questions – the percentage of staff experiencing physical violence from patients, staff experiencing harassment from staff, staff feeling under pressure to work when unwell, staff reporting good communication with management and staff recommending the Trust as a place to work. The Trust's performance has deteriorated against the first two questions.

Innovation, improvement and sustainability

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

Evidence showed staff were encouraged to focus on improvement and learning. We saw examples of innovation such as the development of provision of care and treatment for people with learning disabilities and ethnic minorities.

This service had been involved in the pilot of a new model of measuring patient outcomes for those children living with ADHD called "Attention Star". This is an Outcome Star which measures and supports progress for service users towards self-reliance or other goals.

The dental services carried out epidemiological surveys using national standards and criteria set by the Department of Health to provide information to inform planning of dental services regionally and nationally. Screening of local populations was undertaken where there was evidence needs were unmet to improve oral health and find the most effective way of meeting those needs. We saw evidence of oral health promotion activities including those at schools and children's centres and feedback from children about what they had learnt.

A 'Silver Call' daily multi-agency discharge planning telecom had been introduced in the West locality. This promoted patient discharges at the earliest stage possible and aimed alleviate any barriers to discharges taking place.

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

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

The Trust had been developing a daily capacity reporting tool since early 2013. A project manager was appointed in March 2014 to work with operational teams to develop the tool further and create an electronic real time system for locality teams to report daily capacity, demands and escalation through the management line. The tool had a Green, Amber, Red and Black colour coding system (GARB) that was calculated by using a set of agreed operational triggers. The information was entered into the electronic GARB (e-GARB) which then automatically calculates the risk factors and produces the GARB coloured alert score. Each locality has a GARB escalation protocol to follow depending on the alert score. This tool has enabled the managers in the Trust to have an 'at a glance' overview of the pressures staff were under and it has helped to provide managers with the information they need to be able to divert resources where they were needed most. The next phase of the project will see automatic alert emails being generated to senior managers so that they don't have to deliberately look at the system, they will simply just receive an alert when it is needed.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 Management of medicines **How the regulation was not being met:** The registered person was failing to protect people against the risks associated with the unsafe use and management of medicines. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 Consent to care and treatment **How the regulation was not being met:** The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Compliance actions

Regulation 9

Care and welfare of people who use services

How the regulation was not being met:

The provider had not taken proper steps to ensure that people using the service were protected against the risks of receiving unsafe or inappropriate care by means of the planning and delivery of care and, where appropriate, treatment in such a way as to:

- Meet the service users individual needs,
- ensure the welfare and safety of the service user..

Regulation 9(1)(b)(i)(ii) of the HSCA 2008 (Regulated Activities) Regulations 2010