

Wye Valley NHS Trust

RLQ

Community health services for adults

Quality Report

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Date of inspection visit: 22, 23 and 24 September
2015

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RLQ03	Bromyard Community Hospital		
RLQ21	Gaol Street Clinic	<Placeholder text>	<Placeholder text>
RLQ06	Leominster Community Hospital	<Placeholder text>	<Placeholder text>
RLQ08	Ross Community Hospital	<Placeholder text>	<Placeholder text>

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good I

Overall we found adult community services to be good.

Staff across the service understood the importance of reporting incidents and did so appropriately. Lessons learnt from incidents were shared amongst teams which we saw evidence of. Whilst there were vacancies across the majority of teams, staff felt the current workload was manageable and teams often provided support to each other when demand increased. Specialist services such as multiple sclerosis had insufficient capacity to meet demand. The specialist nurse worked alone and if sick or on leave there was no provision to support the service.

Training levels on subjects such as manual handling and safeguarding varied across community services meaning the knowledge level of all staff was not consistent.

Multi-disciplinary team working was apparent with services using referral pathways as required and there were good links with local GP practices.

Appraisals and peer to peer learning provided staff with time to develop and share knowledge. Staff felt well supported in continuing professional development and were provided with clinical and caseload supervision at regular intervals.

We saw compassionate and considerate care throughout community services. Staff often went above and beyond the requirements of their role to ensure patients received high quality care, including taking information and advice leaflets to patients whilst on their journey home to ensure they felt supported. Staff were extremely passionate about their role in improving patient conditions not only clinically but also emotionally. Well-being was a strong focus in all contacts with patient and consistent positive feedback was given about services provided.

Culture within the community teams was positive and staff felt well supported by their local managers and other colleagues. Teams worked well together and staff engagement was regularly sought. However, we found staff were not aware of a strategy within community services and often felt that changes were rushed which made effective implementation difficult. Staff within community services felt that there was a strong focus on improving acute care and there was minimal recognition for their work at an organisational level.

Summary of findings

Background to the service

Information about the service

Wye Valley NHS Trust formed in April 2011 by the merger of acute, community health and adult social services in Herefordshire.

The trust provides services to 180,000 people in Herefordshire and to 40,000 people in Powys, mid Wales. The catchment area is rural and remote. More than 80% of the people using the services live five miles or more from Hereford city or a market town.

There are 20 trust-wide community services for adults provided from various different locations including community hospitals, outpatient clinics and patient's own homes. Seven district nursing teams based across Herefordshire care for housebound adults' 24-hours-a-

day, seven-days a week. The occupational therapy and physiotherapy services are part of the multidisciplinary neighbourhood team services. The Gaol Street Clinic in Hereford houses services including podiatry and speech and language therapy from 9am to 5pm, Monday to Friday. Multiple sclerosis (MS) and Parkinson's Disease (PD) services are provided across the county by specialist nurses, offering advice and support for adults with MS and PD, their families and carers. This includes how to manage medication and symptoms and health promotion. Our judgements were made across all of the community adult services visited, where differences occurred at particular sites we have highlighted them in the report.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team included one CQC inspector, a registered nurse and a district nurse.

Why we carried out this inspection

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

How we carried out this inspection

We visited five community sites, observing clinics including multiple sclerosis, podiatry, speech and language therapy and falls assessments. We also accompanied community nurses and physiotherapists from four teams on 14 home visits.

We spoke with 42 members of staff, including specialist, district and community nurses, allied health professionals, support workers, administrative staff and directors of services.

During and after our inspection we spoke to 32 patients who have received care.

We looked at 18 sets of patient notes that included care plans, risks assessments and service specific documents.

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?

Summary of findings

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits on 22, 23 and 24 September 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors,

therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

During and post inspection we talked to 32 patients across adult community services. All of the responses we received were very positive about the services they had received with praise mainly relating to the level of care and compassion staff had shown them. Examples of comments included:

- “Help and support has been wonderful.”
- “Absolutely would recommend.”
- “Cannot fault treatment or staff, all excellent, first class all round.”
- “The staff go above and beyond.”
- “Everyone involved has been professional, helpful and caring.”
- “Treatment and staff are superb.”

Good practice

- Compassionate care and emotional support provided by all teams was excellent. Staff had a clear focus for providing best possible care and improving the well-being of patients they saw.

Areas for improvement

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

Action the provider **SHOULD** take to improve

- The trust should ensure all staff have received mandatory training, including safeguarding.
- The trust should ensure waiting times for clinics are monitored to mitigate risk relating to waits over the 18 week referral to treatment time national standard.

Wye Valley NHS Trust

Community health services for adults

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Safety within adult community services was good. Incident reporting occurred regularly and appropriately throughout all areas and staff received feedback when they reported an incident. We saw evidence of lessons learnt from incidents being shared across community services.

Equipment used within clinics and by staff who visited people's homes was clean and well maintained. Records were up to date and quality checked through audits. Records were paper based and staff felt computerised notes would improve services. Individual patient risk assessments were completed regularly throughout all teams.

Good infection control procedures were followed by all staff and were consistent throughout services.

Mandatory training and safeguarding training had not been completed by all staff within community services, with the poorest attendance rates being staff within the neighbourhood teams. Training was occasionally cancelled due to demand and capacity within these teams.

Work had been carried out in relation to lone working following concerns raised in our inspection, staff felt this

had generally improved practices and enabled them to feel safer whilst working alone. Vacancies were present throughout the majority of community teams but staff felt caseloads were manageable most of the time, with support being offered from other teams where required. Specialist services in relation to multiple sclerosis had insufficient capacity to meet demand. The specialist nurse worked alone and if sick or on leave there was no provision to support the service. A business plan was being developed to increase staff within this area.

The introduction of an electronic scheduler allowed teams to manage caseloads more efficiently and plan ahead. Plans were in place to ensure vulnerable people received priority care during adverse weather conditions.

Incident reporting, learning and improvement

- There had been no 'Never Events' in adult community services between July 2014 and June 2015. Never Events are serious incidents that are wholly preventable as

Are services safe?

guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- There had been 48 serious incidents requiring investigation (SIRI) reported for adult community services between July 2014 and June 2015. 75% of these incidents were grade three and four pressure ulcers. We saw good plans in place to prevent further development and treat the present pressure ulcer, through early recognition by newly trained therapy staff in Waterlow pressure risk assessments and further training for district nurses.
- Nursing teams had seen a reduction in the number of patients acquiring grade 2 pressure ulcers due to improved, timelier root cause analysis and more accurate grading by staff. In one district nursing team there was a reduction from seven patients with grade 2 pressure ulcers in July 2015, to zero patients in August. Due to changes to improve incidences only recent being introduced a long term improvement could not yet be seen.
- All staff we spoke with told us that they knew how to report incidents and were able to access the electronic incident reporting system. All staff gave us examples of incidents they would report.
- Managers told us that incidents and themes were discussed regularly at team meetings and feedback was shared with teams along with lessons learnt. We were provided examples of root cause analysis of five recent incidents and saw clear examples of lessons learnt from these.
- Following an incident of a delay in administration of medication, a procedure had been put in place to ensure patients requiring insulin administration were easily identifiable. Staff were called on their mobile phone to request confirmation they knew they were due to visit a patient requiring insulin that day; we saw this system in process and staff told us it worked well.
- Staff and managers were aware of the duty of candour regulations. We saw evidence of patients being informed when there had been a medication error and staff were aware of their responsibilities in relation to being open and honest.

Safeguarding

- The service had a clear safeguarding policy in place. Staff were able to explain and demonstrate they understood the policy and how they used this as part of their practice.
- Staff provided examples of when they had raised a safeguarding alert and told us that they felt well supported by managers with safeguarding issues.
- Patients with pressure ulcers graded three or four were raised as safeguarding alerts, a root cause analysis was then carried out to establish if they were avoidable and required reporting as a SIRI.
- Safeguarding training level was appropriate to the staff grade for both adults and children. Safeguarding training level two attendance rates varied across services. Neighbourhood team nursing staff had 51% attendance whilst speech and language teams had 100% attendance. We were told that training occasionally got cancelled within neighbourhood teams due to capacity but that all staff requiring training had their course booked to complete before the end of March 2016. Up to date safeguarding training figures were displayed within community sites and staff were encouraged to attend at the earliest opportunity.

Medicines

- National Institute for Health and Care Excellence (NICE) guidance were followed when prescribing medication for individual patients.
- Staff within nursing teams regularly administered insulin to patients and we saw guidance in relation to administration and management that was appropriate.
- Patients were encouraged to manage and access their own medication where appropriate. If staff felt patient were struggling with self-medicating they contacted their GP to discuss options available, including pre-filled dosette boxes to simplify administration for them.
- We saw medicine batch numbers being recorded by staff prior to use. Medicines were stored in securely and in line with manufacturing guidance. Staff checked people's dosages and ensured the medicines were in date. Medicine sheets were clearly written and legible should other staff need to review them.

Environment and equipment

- All equipment viewed was regularly cleaned, electrical tested and service records of equipment were available. Medical devices were recorded on the trust's asset register showing service due dates.

Are services safe?

- We saw processes were in place for planned maintenance, the return of used equipment and the procurement of replacement equipment.
- The service had acquired bladder scanners and ultrasound devices which were shared between teams. Nursing staff told us these were easily accessible and a system was in place to ensure their maintenance. During a visit we attended a patient requested further equipment to prevent pressure ulcers and the community staff ordered this advising it could be delivered later that day or the next morning to suit the patient.

Quality of records

- We reviewed a sample of 18 patient records within community sites, patients' homes and during our observation of patient care. Initial assessments, care plan reviews and consent information were fully completed. Records were clear and legible.
- Clinical note audits were conducted in all areas of community nursing in line with trust policy. The results showed signatures were not always present on clinical records which had been shared amongst staff to improve upon. All clinical records we saw contained signatures of all staff caring for the patient.
- The majority of records were paper based within the community. The trust intended to implement a computerised records management system in the future to enable improved sharing of records between services. Records were stored in patient's homes if they received home visits; otherwise they were located at clinic sites and archived where necessary.

Cleanliness, infection control and hygiene

- We attended home visits, clinics and hospital areas. In all settings staff used techniques to prevent spread of infection including hand-washing, use of antibacterial hand gel and use of personal protective equipment such as gloves and aprons. We observed conscientious infection control practice in the care of a patient who was catheterised; this practice was shared with the patient to ensure cleanliness was maintained between visits.
- Information about infection control was displayed on patient and staff notice boards in community based settings and included guidance about correct waste disposal and hand hygiene techniques.

- All clinic rooms has sufficient hand washing facilities and staff working in the community used patient's hand washing facilities where able and were supplied with antibacterial hand gel. Hand hygiene audits are conducted regularly throughout the community hospital bases.

Mandatory training

- Staff told us they had attended or were booked onto mandatory training. Mandatory training was conducted face to face or via e-learning depending on the subject.
- Staff training levels varied throughout the community services. Manual handling training completion by specialist allied healthcare professionals was 100%, whereas completion by neighbourhood team nursing staff was 68%. We found that neighbourhood teams generally had the poorest training attendance rates, when asked staff told us training was occasionally cancelled due to demands but that those who had not completed training did have a course booked before the end of March 2016.
- A new member of staff told us that training had been covered during the induction process. They told us they found the induction useful but that some areas felt rushed while others that were less relevant took longer. During induction staff also received training on conflict resolution and management of actual and potential aggression training which was delivered in conjunction with the main areas of the lone working policy.

Assessing and responding to patient risk

- First assessment appointments were prioritised according to patient need and risk factors. We saw an example of a physiotherapy first assessment being moved forward due to concerns the occupation therapy team had in relation to a patient that had been discharged following a hip fracture.
- Patients had individual risk assessments which were comprehensive, reviewed regularly and shared between any teams working with the same patient.
- Within the endoscopy suite at Ross on Wye staff knew appropriate procedures in managing deteriorating patients.
- A computerised scheduling system had been implemented within the nursing, virtual ward and therapy services. By utilising the scheduling system staff had an oversight of areas with high risk patients and

Are services safe?

responded appropriately. During our previous inspection staff told us they were only able to provide critical and essential services, this had now improved as dependency was shared and predicted more accurately.

- An improved version of the electronic scheduling system was due to be rolled out across all areas which would allow improved management of patient risk.

Staffing levels and caseload

- Staffing levels and skill mix enabled safe practice in most community teams. We saw evidence of vacancies in most teams, recruitment processes were underway to rectify this. The highest rate of vacancies was within nursing team, neighbourhood teams had a total of 5.1 whole time equivalent (WTE) vacancies of band 5 nurses. All staff we spoke with felt able to cope with the demand the majority of the time with the current staffing levels and that staff assisting from other teams helped. Staff felt that this may become more problematic over the winter period when demand usually increased. Staffing and vacancy levels were identified as a risk on the local risk register and the trust wide register.
- Rotas were shared amongst the hubs to enable all staff to see where they may be issues with capacity and where support may be required.
- There had been two incident reports from district nursing staff between January 2015 and September 2015 relating to lack of staff impacting on patient care. Managers we spoke with were aware of staffing constraints and we saw processes in place to move staff around in teams for support to avoid any further occurrences. Vacancies and recruitment plans were discussed openly within the community teams and staff knew where there were vacancies within their own teams.
- Podiatry teams at Gaol Street were fully staffed for the past three months and part-time staff were willing to cover additional hours where necessary to avoid use of bank staff.
- Bank staff were used throughout community services to assist where there was sickness or high demand. Bank nursing staff usage was monitored monthly and a risk assessment tool for decision making regarding bank staff was in place.
- We spoke to staff that worked 'on call' and they told us that they were given an administrative shift the following day, and also that time off in lieu was given for the time they had worked, this was to prevent staff working and driving whilst tired. Staff who had not had been called out were expected to carry out clinical duties the next day where needed, however the following day was always planned as an administrative shift pre-emptively. Staff we spoke with were aware of the policy and felt it was adhered to. Managers audited number of call outs and the appropriateness of the calls. During management meetings the call outs were discussed and if there was an increase in inappropriate calls then this was feedback and learnt from.
- Within the physiotherapy team at Belmont there was a vacancy due to maternity leave, this was not being filled so current staff were sharing the workload between them. Staff told us this was manageable but may not be sustainable long term should demand increase.
- There had been an increase in administrative posts within most community teams, this allowed clinical staff to focus more on patient facing duties. Several staff told us this had benefited the services and enabled better management of staff time and caseloads.
- Assistant practitioner (AP) roles have been introduced within nursing teams. AP's were able to carry out treatments such as administering insulin to non-complex diabetic patients and simple wound dressings and suture removal. All APs had competencies assessed by a district nurse within the team to ensure safe practice. AP roles have helped to share workload across more staff.
- Specialist services such as multiple sclerosis had insufficient capacity to meet demand. The specialist nurse worked alone and if sick or on leave there was no provision to support the service. A business plan was being developed to increase staff within this area.
- Caseload supervision occurred and staff felt this helped to focus on making sure the right patients were on their caseloads within teams.
- The new electronic scheduling system helped staff plan caseloads, visits and forecast increases in demand. We saw this system being used by one of the district nursing sisters who was assigning patients for the following day. Staff had mainly good feedback regarding the electronic scheduling system and felt that it made caseloads much easier to manage and allowed a more succinct view of activity within the teams. Accuracy of the schedule was raised by some staff but they felt this would improve over time with further use and upgrades.

Are services safe?

- We attended a forecast meeting with the neighbourhood team leads and the community service delivery manager, during the meeting caseloads for each area were broken down into nursing and therapy teams which allowed managerial teams to visualise who had higher demand and adjust staffing levels accordingly. We saw one example of where one team were due to be at 80% patient facing time and therefore a team member from another area was asked to move to assist with this. Staff told us they were happy to be flexible to help out colleagues on neighbouring teams.

Managing anticipated risks

- A local risk register was in place for community services. Staff competence to apply compression therapy, district nursing staffing levels and poor signal in certain areas were identified as the top three risks and staff we spoke with were aware of these. We discussed these risks with the service delivery manager and were advised of ongoing plans in place to mitigate risk.
- Staff were able to describe appropriate action should a patient not answer the door or be at home when they arrived for a visit.
- Community services had good systems in place from winter planning and for other weather variables. Volunteer 4x4 vehicles could be acquired as needed and

all staff we spoke with were aware of this service. There was a system in place to flag vulnerable and high risks patients during these times to ensure they were prioritised for visits.

- There was a clear lone working policy and staff were aware of this and how to mitigate risks of lone working.
- Staff told us that safe and well checks were consistent and regular to ensure the whereabouts and safety of staff was known.
- Following concerns staff raised during the previous inspection on mobile phone signal there had been significant work conducted to ensure the most reliable mobile phone network was used. We saw reports relating to the work that had been conducted and all staff levels including a health and safety officer, were involved in this. Following this report the network did not need to change, however staff were now aware of black spots and what to do if they had no signal.
- A taxi service was available to those staff who wished to use it; the taxi would wait outside while the member of staff visited the patient.
- Staff we spoke with felt safer than previously, as managers had listened to their concerns relating to lone working and were supportive of necessary improvements.

Are services effective?

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

Within adult community services there was continued use of evidence based treatment, within national guidance being followed.

Multi-disciplinary team working was carried out and there were good relationships with GP services.

Patient outcomes were measured regularly and feedback on outcomes used to improve services.

Staff shared knowledge through mini learning sessions and personal development was encouraged. Appraisals and clinical supervisions were timely.

Records were stored at community hospitals bases or within people's homes; we saw one incident since January 2015 where a patient's records were not available to district nursing staff visiting out of hours.

Evidence based care and treatment

- Community teams followed national guidance and delivered evidence based care. Staff could give examples of up to date guidance and this was shared regularly amongst teams.
- We saw evidence of the National Institute of Health and Care Excellence (NICE) guidelines being followed in relation to the prevention of pressure ulcers. Within podiatry clinics we saw NICE guidance on diabetic and rheumatoid arthritis foot care accessible to staff and being followed.
- Pathways and clinical guidance were available to staff in a variety of formats and staff knew how to access these.

Pain relief

- We saw staff conducting assessments of patients' pain and offering evidence based advice in regard to the most appropriate pain relief. Staff told us that pain was discussed regularly with patients and they would refer to the patient's GP if they required further input.

Nutrition and hydration

- Nutrition and hydration assessments were completed on appropriate patients. These assessments were detailed and used nationally recognised nutritional screening tools, for example the Malnutrition Universal

Screening Tool (MUST). Dieticians, community nurses and speech and language therapy (SLT) services all worked together to provide advice and guidance to people in the community regarding diet and health.

- We saw evidence that assessments were updated regularly and a change in score/need acted upon.

Technology and telemedicine

- This area was not assessed because there was no evidence available.

Patient outcomes

- Physiotherapy teams told us they had measurable goals to improve patient outcomes. However we did not see any evidence of collated data to show whether patient outcomes were improving or declining.
- District nursing teams measured pressure ulcer occurrence regularly and all community nursing teams had seen a decrease in grade 2 pressure ulcers following improvements in assessment and management. The 'east' team had seen a reduction from seven patients with grade 2 pressure ulcers in July 2015, to zero patients in August. Due to changes to improve incidences only recent being introduced a long term improvement could not yet be seen.
- Expected outcomes were discussed with patients during visits and whether patients felt these were achievable.
- SLT services used patient surveys to look at outcomes, the most recent survey in July 2015 showed that 94% of patients felt their communication issues had improved following treatment within the service.
- Patient feedback was routinely gathered through friends and family tests, along with verbal feedback from patients and thank you cards.
- SKINN bundle audits are carried out quarterly and the most recent audit showed that 100% of patients had received Waterlow scoring, 95% had care plans in place with potential problems identified and 97% of care plans had been updated with re-evaluated since admission to the service.
- Within the SKINN bundle audit it was identified that there were occasions where equipment had not been ordered where indicated post assessment. Within the

Are services effective?

audit it was not possible to establish if this was due to patient choice as the audit did not ask a specific question in regard to this. To rectify this a new question was added to the audit for its next use. Where patients refused equipment this was reported via the electronic incident reporting system.

Competent staff

- Clinical supervision was available to all therapy and nursing teams. Community nursing staff had access to clinical supervision on a monthly basis and could request this when they felt they needed it. Staff told us this time was used to improve skills and felt it was a valuable tool to help them maintain good practice.
- Podiatry staff had supervision sessions at three monthly intervals and these were carried out as group sessions or one to one as requested.
- Preceptorship procedures were in place for new staff, providing them with guidance and assistance within their role. Staff told us good relationships were maintained with preceptors who continued to provide support even after six month preceptorship period.
- Staff have monthly shared learning sessions, within these sessions staff share any new skills or knowledge they have learnt from a training course. The member of staff delivering the learning then received a certificate for doing so. Staff felt this was a successful way in learning as the sessions were short and improved team working and knowledge.
- Development opportunities were available and encouraged amongst teams. Staff said the trust were very supportive of specialised training.
- The majority of staff received six monthly supportive professional development reviews (SPDR).
- Appraisal rates within the neighbourhood teams and virtual ward were at 89.6%, this did not meet the trusts target of 90%. Staff who had not yet received an appraisal told us they had it booked with their manager before the end of March 2016. Staff felt overall that their appraisals were meaningful and that their line manager listened to concerns and learning needs.

Multi-disciplinary working and coordinated care pathways

- Throughout the service staff told us how they worked collaboratively with a wide range of healthcare professionals to promote the health and wellbeing of patients.

- The community nursing teams told us about the multidisciplinary team (MDT) meetings which were attended by a wide range of professionals. The care of each patient was discussed at these meetings on a case by case basis to consider their medical, nursing, social and therapy needs. Community teams told us that MDT working was productive. Staff liaised well with colleagues about patients' requirements and progress.
- Therapy staff provided joint visits to patients where it was beneficial, although nursing teams did not regularly conduct visits with therapy staff we were provided of examples previously where this had occurred.
- Therapy staff were being trained to carry out Waterlow scoring (an estimated risk for the development of a pressure sore) and baseline observations, this helped to share workloads and use patient facing time more effectively.
- Staff felt they had good rapport with GP surgeries and had regular contact with them. MDT meetings and gold standard framework meetings occurred regularly at surgeries between GPs and nursing teams.

Referral, transfer, discharge and transition

- Patients that had been seen by the service for a long period of time were reviewed regularly by senior staff to establish if they were suitable for discharge or required further input from other agencies. Staff felt this was helpful in ensuring caseloads did not become excessive and that patients had timely discharges from service where appropriate.
- Staff did not always feel that discharges from local acute hospitals were well managed. Patients were sometimes discharged home requiring nursing input but the teams were not always informed.
- We saw good communication between teams when a patient went back into an acute hospital setting. We observed the virtual ward team receive a phone call straight after the decision was made for a patient to return to hospital. This meant staff could be assured the patient was safe and also avoid unnecessary visits by staff.
- Referrals between nursing and therapy services occurred often and this was successful. Staff were conscious of cross-over of work and managed this appropriately.
- District nursing staff felt that some patients referred to them would be more suited to practice nurses due to good mobility, they felt this would free up their time to

Are services effective?

see patients who were unable to visit a GP surgery for treatment. Where patients were thought to be suitable for practice nurses, district nurses discussed this with patients and encouraged them to visit their GP surgery for treatment. Referrals came from various areas that contributed to inappropriate referrals which staff felt made it difficult to implement a plan to avoid this.

Access to information

- Community based staff completed and updated records when they visited the patient in notes kept within the patients' home or community setting. We saw one occasion during between January 2015 and August 2015 where patient notes were not available out of hours due to a district nurse taking them back to the office to complete. Learning was not identified from this incident but it was identified that the out of hours visit was not planned and the notes would have been with the patient prior to their next scheduled visit.
- A dashboard had been introduced and produced monthly. The dashboard showed information about the number of patient visits, complaints, compliments, pressure ulcers, sickness rates, annual leave,

outstanding SPDRs, additional hours worked, hours worked by bank staff, referrals and face-to-face training. This was used mainly by management to establish where improvements were needed but also allowed staff to observe the current demands on the service.

- Staff could access trust and professional guidance within the intranet, however staff told us they could not always do this regularly due to caseload demands.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw good practice in relation to gaining consent for information to be shared between services. Patients signed a form to consent to information sharing and who this would be shared with was explained clearly to the patient by the member of staff.
- Consent was gained for treatment and assessment and staff ensured patient were informed fully of what they were about to carry out.
- Most staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and had received appropriate training on this.



Are services caring?

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

All staff showed a strong commitment and passion in relation to providing care and improving patient well-being. Staff carried out their roles to make a difference to people's lives.

Patient feedback was entirely positive about all teams and services provided, with patients and those close to them stating they felt that staff regularly went above and beyond when providing their care.

Relationships between patients, their relatives and staff were truly supportive and showed individual preferences and needs were respected continuously. All staff took time to ensure patients and those involved in their care understood their condition and treatment required.

Staff provided holistic care throughout all community services, focusing not only on improving patients' physical conditions but demonstrated a strong emphasis on wellbeing and emotional support.

Patient feedback from the NHS Friends and Family Test (FFT) showed for June, July and August 2015 that 100% of friends and family would recommend adult community services as a whole.

Compassionate care, dignity and respect

- Patients, their families and carers were exceptionally positive about the care and treatment they received from adult community services. Feedback from those who used the services included "support has been wonderful", "absolutely would recommend", "first class all round" and "the staff go above and beyond".
- Feedback from a family member regarding the community nurses stated their relative received excellent care and that staff discussed the patient's new diagnosis of dementia in a very respectful and helpful way.
- Patient feedback from the NHS Friends and Family Test (FFT) showed consistently that most patients would recommend adult community services to friend and family. Results for June, July and August 2015 all showed that 100% of friends and family would recommend adult community services as a whole. Average results between February and August 2015 was 99.2%, with an average of 52 responses per month.

- Within the SLT service the most recent FFT in August showed that 96% of patients would recommend the service.
- All patients we spoke with told us that clinical and non-clinical staff took the time to speak to them and made them feel welcome to the service. Reception staff at Ross and Bromyard Community Hospital greeted patients and their families in a cheerful manner, asked how they were and if their journey to the hospital was ok. Patients told us this was what they liked about attending the community hospital as the staff made them feel welcome and got to know them.
- All staff told us of their passion for their role as they felt they made a difference to people's lives. Improving outcomes and caring for people was what motivated them to carry out their role.
- Reception staff at Gaol Street Clinic had friendly and personal rapport with patients and their families. Whilst booking next appointments they respected patient's privacy and enquired about any additional needs they may have. Patient told us they liked their approachable and welcoming attitude.
- When visiting patients' homes staff were respectful of privacy and dignity ensuring that patients were covered where able, and curtains and doors were closed. In clinics curtains were provided so that patient privacy and dignity was maintained during examinations, investigations and treatments. All staff ensured that conversations could not be overheard whilst speaking to patients.

Understanding and involvement of patients and those close to them

- Staff within all areas took patients' additional needs and current health conditions into account during assessments and treatment, altering communication to ensure patients were involved in decision making. We observed this in a falls assessment clinic with physiotherapy staff providing a first assessment to a patient with dementia. Time was taken to communicate in a way the patient understood and allowed them to be part of the decision making process.
- Care staff who accompanied patients from care homes were included in assessments. Where patients gave



Are services caring?

consent therapy staff checked that those who cared for patients also understood what was being planned for the patient's treatment. Discussions took place as to whether the care homes had the facilities to support the patient or whether additional help would be needed. Options relating to occupational therapy assessments and home visits were explained to ensure patients and their carers were both supported.

- Patients we spoke with during our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.
- Families of patients we spoke with felt that community staff understood their needs as a family unit and the level of support required. Patients and families told us that being discharged from hospital with reduced mobility or complex health needs was a nervous time and put pressure on family situations, but that staff who visited them made their treatment easy to understand and took the pressure of family members.

Emotional support

- Patients received appropriate support to cope emotionally with their long term conditions. We witnessed positive interactions throughout all community services, staff provided holistic care, focusing not only on improving patients' physical conditions but demonstrated a strong emphasis on wellbeing and emotional support.
- During home visits with the Belmont district nursing team we saw an example of a patient who had struggled to engage with healthcare professionals previously and had self-neglected for a long period. Following

involvement from the team the patient described a dramatic improvement in their wellbeing and social aspects of their life. The patient stated that the care provided from community nursing teams had not only improved their physical condition but given them a better quality of life from their emotional care.

- We saw examples of physiotherapy staff supporting patients to manage their own recovery and feel in control of the pace at which it was carried out. Patients from this service told us that rather than just being given instructions they felt that they were truly involved and that this helped their anxiety and worry.
- Staff took into account patients' normal lifestyle when providing treatment. A patient we visited for physiotherapy treatment was a regular user of the local gym prior to their injury and described being less active as frustrating. Gym sessions were factored into the patients treatment plan to encourage normal activities to continue during rehabilitation.
- During consultations any available support services or helplines were discussed with patients and then followed up during the next appointment to establish if they were helpful.
- Patients felt they built relationships with staff from the services and could openly discuss their wellbeing during appointments and visits. Relatives of patients commented on how emotional support was also provided to them and this was welcomed as some felt that caring for a close family member was "sometimes worrying."
- Patients that attended 'leg clubs' stated they allowed a social element to their care and that meeting with other patients with similar conditions helped them to feel less isolated and that nursing staff being there to provide support enabled them to ask questions.

Are services responsive to people's needs?

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

The services provided a range of interventions to prevent admission to hospital and to facilitate discharges from acute settings.

Staff had a good understanding of equality and diversity.

Clinics and visits generally were on time with minimal cancellations. Referral targets were not being collated but patients told us they generally did not have long waits to be seen by any service.

Patients were encouraged to seek help between appointments where needed and appointments were flexible. Home visit services were provided to vulnerable people who were unable to attend clinics.

Complaints were managed appropriately and action taken to rectify issues in a timely way. Information regarding how to complain or give feedback was within patient records at their home and identified to them during their first visit.

Planning and delivering services which meet people's needs

- Adult community services provided integrated care for people in their own homes. We were provided of examples of district nursing teams working with occupational therapist and GPs to ensure services were suited to the patients' complex needs.
- A range of services were provided to prevent admissions to hospital and facilitate discharges. A variety of treatments were provided along with therapeutic interventions including physiotherapy and falls assessments.
- Hospital at home services provide 24/7 cover and the pilot scheme was deemed successful, resulting in further roll out. Included in the team were community matrons, staff nurses, physiotherapists and occupational therapists. The service allowed patients to be discharged by hospital consultants to their own home and have continued support until they are well enough for discharge to other community teams or their GP.
- The introduction of time slots within nursing visits allowed patient choice and flexibility.
- Facilities were appropriate for services required and were accessible to all patient groups.

- Notices in the patient waiting rooms told patients how to access a number of support groups and organisations.

Equality and diversity

- Nursing staff gave us examples of when they had visited patients who had strong cultural and religious beliefs. The staff member who saw the patient improved their knowledge on the patient culture to enable them to have a better understanding of the patient's beliefs and needs.
- Staff we spoke with demonstrated a good understanding of equality and diversity. Data we were provided with showed good completion of equality and diversity training with the level appropriate to the staff role.
- Telephone translation services were available where necessary and staff knew how to access these. Staff allowed family members to translate but not when consent for treatment was required. This is not in line with the trusts policy.
- Leaflets were not routinely on display in languages other than English, but were available on request.

Meeting the needs of people in vulnerable circumstances

- Community nursing and therapy staff knew who the vulnerable patients were within their caseloads and were able to prioritise these. The electronic scheduler allowed high risk and vulnerable patients to be identified to all staff accessing the system.
- Patients told us that if they had problems getting to podiatry clinics due to mobility or other issues the staff were helpful in arranging home visits to ensure patients were seen in a timely manner.
- Therapy and nursing teams had good knowledge of how to improve care for those living with dementia.
- During visits with district nursing teams we saw care of a patient with chronic mental health problems and they showed a full understanding of how these their conditions affected their compliance with self-care, giving advice to the patient accordingly.

Access to the right care at the right time



Are services responsive to people's needs?

- During our inspection the trust were not effectively collecting referral to treatment time (RTT) data. However staff from community services told us they felt that RTT times were on target with the exception of nail removal surgery which sometimes was over 18 weeks. This was due to the required premises being shared with other services. We did not see risks assessments for those who were waiting longer than 18 weeks.
- Patients we spoke with following their clinic appointments told us that they had never experienced problems booking appointments within the necessary time frame for their next treatment.
- There had been an introduction of visits slots within nursing teams. This meant patients knew if their visit would occur in the morning, afternoon or evening. Patients told us this allowed them to carry on daily life and not have to wait in all day for their visits.
- Staff told us that equipment such as pressure relieving cushions, mattresses and walking aids were easily accessible. Satellite stores were around the county and enabled this accessibility.
- We saw staff encouraging patients to phone the clinic with any problems between appointments and where required urgent appointments would be arranged.
- Community services were provided in people's homes where required and clinics were available within local community hospitals. Community hospitals were located across the county making them accessible.
- Seven day services were available through district nursing teams and the hospital at home scheme. There was an on call service for district nurses, staff within hospital at home provided 24 hour cover.
- Specialist multiple sclerosis services provided clinics at several of the community hospitals rather than one which allowed the service to be more accessible to patients across the whole county than when it was only run from one site. However due to being run by only one member of staff with demand high all anticipated

services could not be provided, for example home visits to patients. A business case for another member of staff was in the process of being signed off to increase capacity of the service.

- 'Leg clubs' occurred within two of the nursing teams. The clubs allowed patients requiring dressing or other treatments for leg conditions to meet together and have treatment following one another. This enabled patients to have a drop in type appointment as opposed to a set time. It was planned to roll this model out in two further teams.

Learning from complaints and concerns

- Staff told us they try to deal with complaints within their teams where possible, if however this was not possible they were given Patient Advice and Liaison Service (PALS) information to enable patient to raise their concerns. Reception and administrative staff at all sites were aware of PALS information and had leaflets available for patients.
- Patients felt happy with the level of care provided and felt staff listened to any concerns they had. Patient could not always tell us how they would make a complaint but stated they thought this information was available in their files but they had not read it as they had no need to complain at present.
- We saw staff showing patients where information was located within their folder to allow them to provide feedback on the service.
- From feedback community services had learnt that not being given a time when therapy or nursing staff were going to visit restricted patient ability to carry on day to day activities. From these concerns the service provided patients with morning, afternoon or evening appointment slots. Patients told us this allowed them more freedom and they didn't have to wait in all day as previously. The majority of patients were happy with the time slots.
- Lessons learnt from complaints were shared widely in adult community services not just within the team it related to.

Are services well-led?

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

Leadership within adult community services was good. All staff levels felt supported by their immediate managers and senior managers within the community. Staff had limited knowledge of strategy within community services but there was an awareness of the trust's new values with some staff taking part in workshops to develop them. There was knowledge of the trust leadership team and of the executive link system.

New standard operating procedures had been introduced to ensure a consistent and standardised way of working across all areas.

Staff felt able to suggest new initiatives for improving care and efficiency within their service, and generally felt involved in changes within community teams. Changes were not always fully implemented and embedded with staff feeling like they occurred to quickly to ensure maintenance.

Management and staff had proactively looked at the previous 2014 inspection report and made clear improvements together to shape the service.

Service vision and strategy

- New trust values were in the process of being rolled out during our inspection. Although they had not been widely shared many staff had been involved in the workshop to develop them and were aware of what the values were.
- The current strategy for adult community services was not known amongst the majority of staff, including some managers.
- Most staff felt that there was a disconnect between community and acute services within the trust as a whole. They felt that the trust focus was on improving acute care and there was minimal recognition for the work that had been completed in community services.

Governance, risk management and quality measurement

- Regular audits were conducted within all areas of adult community services, these included appointment times, records, pressure ulcer occurrence and equipment provision. Audit results were shared and learnt from where appropriate.
- There was a local risk register for community services and this were updated and maintained. Managerial staff were aware of the top three risks; vacancies within nursing teams, competent staff in relation to compression therapy and mobile phone signal, and could describe the impact this had within their service. Phone signal was given as an example of how work had been carried out to reduce the risk to staff and patients, ensuring staff knew where signal blackspots were and procedures for regular welfare contact with staff. However there were no risks identified in relation to high demand for specialist services such as multiple sclerosis and staffing levels not meeting this demand.
- Daily risk stratification meetings were held, along with weekly team and senior staff meetings to ensure any potential risks were monitored and that quality was maintained throughout services.
- We did not see any evidence of meetings relating to root cause analyses of incidents, however themes and trends were shared within team talks and trust briefs.
- The service delivery manager (SDM) of adult community services had made evident improvements following recommendations after the last inspection of the service. They showed a clear and open attitude to improving community services and were willing for change to improve patient care. Staff we spoke with knew who the SDM was and described them as passionate and approachable.
- A large number of standard operating procedures (SOP) had been put in place to enabled standardisation of practice throughout community services, we saw examples of these during our inspection.
- Some staff felt that although the majority of changes within adult community services were an improvement on previous practice, they happened too quickly. Staff described changes as not always being embedded fully before the next change was implemented. An example we were given of this was the dashboard containing

Are services well-led?

nurse sensitive indicators. Staff felt this tool appeared very suddenly and felt like a punitive measure of staff performance. Staff felt that it was not fully discussed prior to implementation and had poor staff buy in.

Leadership of this service

- Within podiatry services there was a professional development lead as well as clinical leads. Staff told us managers are visible and they receive “excellent support.”
- Staff from all areas we visited felt that local and senior leadership members had improved their visibility and relationships with staff since the last inspection. The director of nursing had regular contact with nursing teams and staff knew who oversaw their teams.
- The trust had developed an executive link system between services. All staff from community services were aware of who their executive link was and their role.
- Regular meetings took place to allow effective communication between teams and managers. Targets were in place for attendance at staff meetings, these were monitored and if staff attendance was not meeting trajectory for the year an action plan was put in place to improve. A conference call facility had been enabled recently to provide an option for staff who were working to be able to have input within the meetings. Trust level meetings could also be attended by video conference by community staff who could not attend in person.
- Staff told us they felt supported by colleagues and managers and felt they were listened to the majority of the time.

Culture within this service

- All staff we spoke with felt there was a hardworking and passionate culture within the service, focused on patient care. Morale was described as good amongst teams.
- Team working was evident and staff were encouraged to share views and thoughts between each other.

Public and staff engagement

- Patient feedback mechanisms had improved following the last inspection. Previously patient views had not been regularly collated and verbal feedback was relied upon. We saw that results of patient feedback was looked at and acted upon on a regular basis.

- Patient files within their own homes contained a variety of information on how they could feedback their views and this was encouraged by staff during visits.
- Regular phone feedback was obtained from patients to ensure they were happy with the care and treatment being provided to them.
- Staff from all community teams were encouraged to read the last inspection report to look at where improvements were required. The Leominster district nursing team had worked well together to look at areas that were relevant to them and work with management teams to improve their services. Staff felt part of driving developments forward.
- The 2014 NHS Staff Survey showed that staff felt they were able to contribute towards improvements at work and the score for work pressure felt had improved since 2013. However staff working extra hours remained worse than the national average, not changing from 2013.
- ‘Time to have your say’ sessions were in place to allow staff to drop in and discuss their concerns and response on any activity undertaken.
- Financial constraints of the trust had been openly discussed with staff and their involvement in reducing costs was sought. Nursing staff had been informed of associated costs with certain dressing types and with this knowledge could chose alternatives where appropriate. Staff felt this information regarding cost helped them feel involved in choices within the service and made them more aware.

Innovation, improvement and sustainability

- Staff from all areas told us they felt supported to implement new innovations and ideas. Discussions about areas team were proud of enabled good practice to be sustained and shared; we saw this within the Leominster nursing teams.
- Enabling staff to conduct their own mini teaching sessions helped improve skills and was sustainable as they were carried out in 10 minute sessions along with meetings. ‘Thank you’ certificates were issues to staff that led a teaching session. Staff had very positive feedback about the introduction of these sessions
- Following the trust’s last inspection staff had positive feedback on improvements that had been made to adult community services, they felt communication, visibility of leadership and engagement had all made constructive changes to the services they provided.