

Southern Health NHS Foundation Trust

RW1

Community health services for adults

Quality Report

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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)
RW194	Alton Hospital		GU34 1RJ
RW1FY	Romsey Hospital		SO51 7ZA
RW158	Gosport War Memorial Hospital		PO12 3PW
RW170	Petersfield Hospital		GU32 3LB
RW1YM	Lymington New Forest Hospital		SO41 8QD
RW1AC	Parklands Hospital		RG24 9RH

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

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

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

Summary of findings

Ratings

Overall rating for the service

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

- The trust had many examples of responsive teams working collaboratively to meet their patients' needs. They provided care close to or within the patients' home environment, thus reducing hospital admissions. Staff used comprehensive holistic patient risk and care assessments, to identify and respond to risks including the safety, health and wellbeing of patients in the community within their care.
- Each team and area was involved in delivering the trust's strategy and goals. Each team developed its own set of objectives that were in line with the trust's vision and strategy. The trust staff followed process and set procedures to report safety incidents and manage risks. However, because most staff did not use their laptops when delivering care in the community, there were sometimes delays in reporting incidents. The teams used a dashboard system to monitor serious incidents, staffing information and patient feedback. Most staff had learning from incidents shared with them.
- Staff had a good understanding of their responsibilities toward the Duty of Candour requirements. Patient and their families received compassionate, focused care, which respected their privacy and dignity. They told us they were involved in planning their care and without exception, patients we spoke with praised staff for their kindness, caring and empathy. Most formal patient feedback was positive, although where there were complaints; clear action plans were in place. Community services for adults provided care based upon the latest national guidance from the National Institute for Health and Care Excellence (NICE). There was multidisciplinary team (MDT) working across all the teams we visited, including working with health and social care professionals from other organisations. Staff had mandatory

training and most had had appraisals and access to personal development. Most staff felt supported, listened to and well supported by their immediate line managers and the executive team.

However

- The geographical differences in the location of services and in their commissioning and delivery meant that there were differences in the delivery of care across both areas. Some community teams had significant registered nurse vacancies. The safety of patients could be affected while they were waiting for visits and staff were concerned that their workload was too high to care for patients properly.
- Staff did not always update patient records in a way that kept patients safe. The trust had invested in products to help staff complete electronic records in the community and at patients' homes. However, staff chose not to use these tools. This meant records were not made at the point of delivery of care, which posed a risk of incorrect information being recorded. This was the same as our findings during the inspection of community services for adults in October 2014. In many patient homes, their plans of care were not their current plan of care.
- There were significant delays in the provision of wheelchairs and repair service through an external provider, which affected the safety and well-being of many patients receiving adult community services in different localities. Staff told us about vulnerable patients being kept in bed at home because of a lack of appropriate seating.
- There were delays for some patients accessing outpatient clinics and services, with between 11% and 14% not having an appointment within the trust targets..
- There were some examples of poor medicine management, lack of understanding about safeguarding and infection prevention practices. However, these were generally isolated incidents rather than systemic issues.

Summary of findings

Background to the service

Southern Health NHS Foundation Trust received Foundation Trust status in April 2009 under the name Hampshire Partnership NHS Foundation Trust and in April 2011, it merged with Hampshire Community Health Care. Southern Health NHS Foundation Trust provides adult community services to support people in staying healthy, to help them manage their long term conditions, to avoid hospital admission and following discharge from hospital to support them at home. Services are provided in people's own homes and clinics in community or hospital bases across all of Hampshire.

The community services for adults includes:

- Community nursing and therapy services
- Rapid response teams
- Specialist nurse services
- Community Stroke team
- Diabetes education and advice service
- Rapid Assessment Units
- Enhanced recovery at home
- Wheelchair service in the north of Hampshire

The services work closely with colleagues in older people mental health services, adult social care services, care homes and GPs.

Our inspection team

The team that inspected community health services included CQC inspectors, an Expert by Experience (a carer

of someone who had used services) and a variety of specialist advisors including community nurses, community managers, tissue viability nurse, physiotherapist and a GP.

Why we carried out this inspection

We carried out this short notice inspection of Southern Health Foundation NHS Trust to follow up on some areas

that we had previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service.

How we carried out this inspection

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

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

Before visiting Southern Health NHS Trust, we reviewed a range of information we hold about the core service. We carried out an announced visit on 28-30 March 2017.

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

Summary of findings

We visited community services provided from clinics at various locations including many of the trust's community hospitals. We visited outpatient departments, rapid assessment units and diagnostic imaging departments at some of the trust's community hospitals.

We reviewed 35 care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

As part of the inspection, we spoke with 106 individual staff members, 92 patients and 26 relatives or carers.

What people who use the provider say

We spoke with 92 patients as well as 26 carers, relatives and loved ones covering all adult community services we visited over the three days of our inspection.

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

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

The comments that we received from patients and carers showed how they valued the service being delivered to them, they said the staff 'all so nice, they will do anything for you', "staff treat me like a person and listen to me" and "they listen to questions and answer so we can understand."

The patients described how the staff considered them holistically, including supporting their relatives or carers as well as themselves.

Areas for improvement

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

Action the service **MUST** take to improve

- The trust must ensure all staff understand and recognise safeguarding concerns
- The trust must ensure all staff escalates safeguarding concerns following the trust and local authority safeguarding procedures.
- The trust must ensure medicines at the Alton intravenous clinic are stored securely and that only staff who need to access the medicines.
- The trust must ensure that it works with the commissioners to improve wheelchair provision for community service patients.
- The trust must ensure all staff understand their responsibilities towards the mental capacity act.

- The trust must ensure patient records are accurate and up to date.

Action the service **SHOULD** take to improve

- The trust should support staff to report incidents in a timely manner
- The trust should ensure staff follow infection prevention best practice guidelines while providing care in patients' homes.
- The trust should have an appropriate tool to monitor and detect deterioration in the condition of patients who have long term conditions, receiving care and treatment in their own homes, who may routinely have abnormal physical signs
- The trust should review whether there is a need for a night nursing service across all areas.
- The trust should ensure all medicines are in date.

Southern Health NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

We are not rating the trust on this inspection

- Staff did not always report incidents in a timely manner.
- Staff did not always recognise and escalate safeguarding concerns.
- Storage of medicines in the intravenous clinic and Alton Hospital was not secure and some medicines had passed their expiry date.
- Delays in wheelchair provision and repair service (through an external provider) affected the safety and wellbeing of many patients who received adult community services.
- Patients' records were not sufficiently managed to keep patients safe. Delays in staff making entries in patients' records increased the risk on incorrect information being recorded. Delays in making entries in patient records did not meet the Nursing and Midwifery Council code of practice regarding patient records. Care plans held at patients home were not current.
- Not all staff in the community teams followed infection prevention best practice guidelines.

- There were shortages of staff in some community teams, which resulted in patient visits being transferred to the out of hours GP service.

However,

- Changes in practices were made as a result of learning from incidents.
- Most staff were up to date with mandatory training.
- Staff used comprehensive holistic patient risk and care assessments to support planning of care.
- Support to all staff from the tissue viability nursing team resulted in a reduction in the number of pressure ulcers reported

Safety performance

- The trust recorded all pressure ulcers. Monitoring for the period April 2016 to March 2017 showed there had been 18 pressure ulcers causing major harm to patients, and 148 causing moderate harm. The majority of pressure ulcers reported caused low or no harm to the patient.

Are services safe?

Incident reporting, learning and improvement

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. They reported incidents and were able to discuss them with their line managers. They gave us examples of a range of reportable incidents such as accidents, pressure ulcers, and medication errors, responding to premature and inappropriate hospital discharges, slips, trips and falls.
- However, common practice was that staff entered the incident onto the electronic system once they had finished their visits and had returned to their office based. This meant there were delays in reporting incidents. This was the same as the findings at the previous inspection of community services for adults in October 2014.
- Most staff told us they received feedback about incidents reported, including the outcomes and lessons learnt from investigation of incidents. Staff shared examples of where practices had changed in response to incidents. This included the introduction of 'gluco hero' nurse and health care assistants (HCAs) to lead on diabetes and insulin, in response to insulin administration errors. Another example was ensuring patients being transferred to Xray in the rapid assessment units, were transferred in a wheelchair following an elderly patient's fall when they were transferred by walking to the Xray department.
- There was a structured process for responding to pressure ulcer incidents. Staff reported all pressures ulcers, grade two and above, as incidents. These were discussed at a panel meeting within a week of reporting. A tissue viability nurse and staff from the service who reported the pressure ulcer attended the panel meetings. The panel made decisions about the reason for the development of the pressure ulcer, whether any other agencies such as the local safeguarding authority, needed to be notified, whether a root cause analysis investigation needed to take place. Lessons and actions from the panel meetings fed into the quality improvement programme for the individual teams. Themes from weekly pressure ulcer panel meetings were included in the Hot Tips governance newsletter that was available to all staff.

- Most staff felt the approach to reporting incidents had positively changed since the last inspection of community adults services. This included all staff reporting incidents on the electronic reporting systems, swift feedback about reported incidents and a culture of support and learning in response to incidents. However, this was not experienced across all services. Staff working for the Gosport community teams said they received little feedback about reported incidents.
- The trust monitored trends and themes in incidents using their governance and quality dashboard. Individual services accessed the dashboard to monitor trends and themes occurring in their service.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incident' and provide reasonable support to that person.
- Staff we spoke with were aware of their responsibilities to be open and honest following incidents that caused moderate or severe harm to a patient.
- The incident reporting process promoted staff to consider whether staff needed to follow the duty of candour process.
- Tissue viability nurses said that although duty of candour was considered during pressure ulcer 'panel meetings', there were no templates specific to the tissue viability service to write to patients. They told us they were in the process of developing appropriate paper work for this process.
- The trust monitored their performance against the duty of candour process. This showed between April 2016 and March 2017 compliance with the process had steadily improved. Most teams achieved 100% compliance with patients receiving the outcome from investigation of the 'incident.' Information collected by the trust identified themes that resulted in them following the duty of candour process. This included development of pressure ulcers, accidents or injuries to patients, infection, prevention and control incidents and medicine management incidents.

Are services safe?

Safeguarding

- The trust told us all non clinical staff received level 1 safeguarding training for adults and children, clinical staff received level 2 safeguarding training for adults and children. Staff told us they had completed this training.
- We found areas of practice within several services that indicated staff did not fully consider the need to safeguard vulnerable patients. In some community multidisciplinary team meetings that we observed, staff discussed patients whose circumstances should have prompted a safeguarding alert or action to protect the patient. This included a patient with dementia who lived with a relative. The relative could not understand the rationale behind the care being provided, which had led to the patient lying in a faeces stained bed, and cats walking over food preparation areas. This meant the patient was living in an environment that could cause them harm. A second patient was discharged from the local acute NHS hospital to an unsafe home environment. This included no food in the house, no plans for the provision of food for the patient and a dirty home environment with no clean area to prepare food.
- During an observation of care with one of the district nursing team, we saw staff left the key to a vulnerable patient's home hanging on a string on the doorframe of the front door to their home. A review of this patient's records showed this was normal practice. We escalated this concern to the trust during the inspection. The trust responded by submitting an incident report, alerting and taking advice from the local authority safeguarding team, and liaising with the patient's power of attorney to arrange for the provision of a key safe, This would ensure only authorised staff had access to keys to enter the patients home..
- However, observation of team handovers, other multidisciplinary team meetings and discussion with staff showed most staff had a good understanding about safeguarding and safeguarding procedures and knew how to report safeguarding concerns.
- Records provided by the trust showed that 97% of all staff had completed safeguarding adults level 2 training.

Medicines

- The trust had a medicines policy that detailed specific arrangements for medicine administration in people's homes.
- We saw teams used competency-based assessments of staff to support safe medicine administration practices.
- Some nurses across the community services had completed accredited training to be independent prescribers. This meant they could respond to patient's needs and prescribe appropriate medicines in a timely way. They told us they received regular prescribing updates and supervision.
- Where nurses were not independent prescribers, they liaised with patients' GPs for the prescription and review of medicines.
- Staff followed trust processes to ensure prescription pads were stored securely. There was traceability of the use of prescriptions.
- We saw medicines were stored securely with the exception of medicines for the intravenous clinic at Alton Community Hospital. Bags of saline and ampoules of saline and water for injection were on open shelves and trolleys in the preparation room. The door to the preparation room was wedged open. This meant the intravenous infusions were not secure. We escalated this to the nurse running the intravenous clinic, who said they would shut the door. When shut, staff accessed the room using a key pad. However, access to the room was not limited to only those staff who required access, non clinical staff including porters and cleaning staff knew the access code. This meant risk of tampering with the medicines was not protected.
- The intravenous clinic also shared a cupboard with the inpatient ward for storage of other medicines. The cupboard was not large enough to accommodate the medicines in an organised manner. Patients own medicines were mixed with stock items. We found 'out of date' medicines stored in this cupboard.
- The management of prescription pads meant staff stored them securely and there was an audit trail to ensure staff used them appropriately. This was an improvement since the inspection of the service carried out in October 2014.

Are services safe?

Environment and equipment

- Staff working in the community expressed concerns there were still some delays in accessing equipment for patients. They lessened the risk of patients not receiving the appropriate equipment, by ordering equipment in anticipation of patients' needs. However, staff working in the Winchester community areas said that due to the difficulties in accessing equipment, the lack of equipment was included in their risk register. Staff working in the Lymington community area, said there had been no new stock of equipment in the last two years. This meant they had run out of equipment such as mobility aids. In order to meet patient needs they had purchased mobility aids out of their own budget.
- There was disparity in the provision of wheelchairs for patients whose care was managed by the trust. The trust had its own wheelchair service located at Basingstoke which was commissioned by the local clinical commissioning groups (CCGs) to provide a wheelchair service for people living in the north region of Hampshire. Staff reported that this was a very responsive service that provided wheelchairs and repairs to wheelchairs for patients in a timely manner. However, wheelchair provision in the south of Hampshire was commissioned by the CCGs to a private provider. Staff reported this was a very poor service. Patients could sometimes wait up to two years for the provision of a wheelchair. Staff described the impact this had on patients; increased risk of development of pressure ulcers, less effective rehabilitation resulting in less independence and increased dependence on health and social care organisations. The poor provision of wheelchairs meant there was risk this affected the mental wellbeing of patients, as well as preventing them accessing the community and taking part in social activities. When we spoke with staff they were unsure what action the trust was taking to facilitate improved access to wheelchair services for these patients. The trust provided evidence that these issues had been raised with commissioners. However, staff could not identify any improvements being made in the wheelchair service for their patients.
- Since the last inspection, the trust had purchased new resuscitation equipment for their locations. Records showed staff checked this equipment according to the trust's policy. Staff knew where to locate resuscitation

equipment and how to summon assistance in an emergency situation. This included equipment and assistance in locations the trust delivered services from, but did not belong to them.

- The community service provided an outpatient ophthalmic laser service at Lymington New Forest hospital. Staff used electronic safety signs to alert other staff when the laser equipment was in use, which reduced the risk that people would enter the room and be exposed unnecessarily to lasers, which could cause damage to eyes or skin.
- The most recent report by the radiation protection advisor, in November 2016, had no concerns with the safety of the environment and use of equipment in Lymington Xray department.

Quality of records

- The management of records meant there was a risk patients would not receive care and treatment to fully meet their needs. The trust used an electronic patient record system, and staff were provided with laptops for recording records of care and updating care plans in patient homes. However, this process was not followed. This led to delays with staff entering records onto the system meant staff were not assured records were current and accurately detailed the wellbeing and treatment of patients.
- Staff recorded patients' plans of care on the electronic record. Most plans we viewed on the electronic system, accurately detailed patients' current plans of care and previous reviews of plans of care. Paper copies of care plans were kept at patient's homes. However, when we looked at care plan documents in patients' homes, they were not current and did not provide guidance for staff about the current care needs of patients. Staff did not access their laptops in patients' homes to look at patients' current care plans. This presented a risk that staff would deliver care in line with the care plans kept in patients homes. These were not current, did not meet the needs of patients and did not promote the safety and wellbeing of patients. For example, we saw a community nurse carrying out a wound dressing that did not follow the wound care plan detailed on the patient's electronic records.
- Community staff used note pads to record basic notes about the care and support they had delivered to

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patients. This was used to support them to enter full details on the electronic system. Some staff told us, they sometimes had to complete electronic records at home in their own time. A lack of time at work meant some staff entered records onto the electronic system up to a week after they had provided the care and treatment. This meant patient records were not entered at the time of care, which increased the risk of them entering incorrect information onto patient's records. This was the same as the findings at the previous inspection of community adults in October 2014.

- This practice did not follow the Nursing and Midwifery code for "Professional standards of practice and behaviour for nurses and midwives." This code states "Keep clear and accurate records relevant to your practice this includes but is not limited to patient records. It includes all records that are relevant to your scope of practice. To achieve this, you must: complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event." Staff did not detail that notes entered onto the electronic system were written after the event.
- In contrast to most teams, we found the Winchester community teams entered details in patient's records in patient's homes on laptops using the 'store and record' programme.
- Electronic records were password protected, to ensure only authorised staff had access to the records.
- The trust carried out audits of patient records. The latest audit identified many staff did not use their laptops in the community settings to complete patient records.
- The trust was working to adjust the care plans to make them easier for staff to use.

Cleanliness, infection control and hygiene

- The community bases and clinic environments we visited were clean and free from clutter.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinics and home environments. We observed a high level of compliance with hand hygiene, isolation and the correct use by community nurses of personal protective equipment (PPE) such as gloves and aprons. Staff adhered to the trust 'bare below elbows' policy in clinics and home environments.

- Hand washing facilities and alcoholic hand gel were available throughout clinic areas. Staff, we observed, followed good infection control practice and procedures when working in the community. However, we observed a few examples of poor practices in respect of cross infection prevention in some of the community setting. One community nurse for one patient did not wash their hands before administering insulin. The same nurse for a second patient wore gloves for administering insulin, but also made a telephone call wearing the gloves before administering the insulin wearing the same gloves. A second community nurse, in a different location used the floor of a patient's house to open a wound dressing pack on the floor rather than using an available coffee table. This meant patients were at exposure to a possible risk of infection.
- Each team had an infection prevention and control link nurse. They carried out hand hygiene audits four times a year. The latest hand hygiene audit report (October to December 2016) showed a range of 84% to 100% of staff fully met the trust's hand hygiene policy. A range of staff including nurses, healthcare assistants, student nurses, medical staff and therapists, were assessed as part of the audit.

Mandatory training

- Staff across the different teams described good access to mandatory training. There were effective systems to alert staff and their managers when mandatory training needed to be repeated.
- The trust monitored compliance with mandatory training. The trusts target for compliance with mandatory training was that 95% of all staff must complete the training. Information provided by the trust showed that the compliance rate in March 2017 was between 94% and 98%.

Assessing and responding to patient risk

- Nurses completed holistic patient risk and care assessments during home visits. The assessment supported staff to identify risks, such as risks of developing pressure ulcers, risk of malnutrition and risk of falls. Where staff identified risks, they developed care plans detailing the actions staff needed to take to reduce the impact of that risk to the patient.

Are services safe?

- The tissue viability nursing team supported all staff with the management of wounds and the prevention and management of pressure ulcers. The tissue viability nursing team said that the pressure ulcer prevention plan, developed by them, had resulted in a 52% reduction in grade 3 and 4 pressure ulcers between April 2015 and March 2016. Staff working in the community said the tissue viability nursing team supplied them with a quick reference card and mirror to aid early identification of potential areas of damage to skin integrity.
- The tissue viability nursing team provided training to staff about the prevention and management of pressure ulcers. However, this training was not mandatory, so the tissue viability nursing team did not have detail about how many staff had completed this training.
- Some areas had developed local tools for monitoring pressure ulcers. The Gosport community nursing team had developed their own tracker tool to monitor the progress (improvement or deterioration), for their patients who had pressure ulcers or were identified as at risk of developing pressure ulcers. The tracker tool also monitored contact with relevant health professionals, such as the tissue viability team or occupational therapist, involved in the management and treatment of the pressure ulcer.
- The 'track and trigger' tool used by the trust to monitor patients' physical health and support staff to identify whether a patient's condition was deteriorating did not provide appropriate guidance for staff. The tool used a scoring system to support staff to identify when a patient's condition was deteriorating and guide them about what escalation action they needed to take. However, the escalation guidance in this tool was not always appropriate for community patients with chronic conditions and who did not include 'normal' physical signs. For example, the normal breathing pattern for a patient with chronic lung disease would register on the track and trigger tool as requiring urgent medical assistance and monitoring of physical signs every fifteen minutes. Matrons told us discussions were currently taking place about the escalation process for community patients.
- Community teams had handover periods during the middle of the day, where they discussed patients they had concerns about. This ensured the whole team were aware of patients who were at risk of deteriorating and the action staff needed to take to support the patient. This also supported staff to identify patients whose conditions meant the twilight nurses needed to visit them in order to reduce risks to their wellbeing.
- Staff discussed plans for patients with complex needs at multidisciplinary team meetings held weekly for each community team. This ensured patients with complex needs received the care and support they required.
- Staff working in Xray departments asked female patients whether there was a possibility of them being pregnant before proceeding with Xrays. Staff working in the Xray department at Lymington New Forest Hospital told us that the most recent pregnancy questions audit showed compliance of only 63%. They explained this result was due to documentation issues, rather than actual practice. However, this meant that they could not evidence women were asked about their possibility of being pregnant before Xrays were carried out.
- Respiratory nurses in north Hampshire described the work they had done with the Southampton central respiratory network to develop a risk tool for patients having oxygen therapy at home. The company dispensing the oxygen to patients' homes had also been involved in this development and now did not dispense oxygen to a patient's home unless the prescription had the risk tool completed.
- At the previous inspection of community services for adults staff in one location did not know the local procedures for calling for assistance in the event of a medical emergency. At this inspection staff at all the locations we visited knew the local process for summoning assistance in the event of medical emergency.

Staffing levels and caseload

- Community staffing (nursing and therapists) was a challenge for the trust, with a number of areas having vacant posts. Overall vacancy rates for community services for adults was 5%. The trust had identified that a higher proportion of staff left employment within a year of commencing employment. Across teams this was between 25% and 33%. Overall turnover of staff was

Are services safe?

between 13% and 20%. The trust and individual teams told us they were exploring reasons why a significant number of staff left within a year with the aim of taking actions to support retention of staff.

- In some areas although the numbers of nurses had increased, the skill mix was a concern. There were a large number of junior or recently qualified nursing staff, which meant there was only a small pool of experienced community nurses.
- Community nursing staff told us they rarely used agency staff. This was due to the challenges of lone working. Where possible, they used bank staff or their own staff working extra hours, to cover vacant shifts. The trust told us that around 5% of the current work force was made up of bank or agency staff.
- The trust used agency therapists to cover long term absence or vacancies in some integrated teams
- The trust had developed a staffing tool based on the acuity of the patients and assistance staff needed to travel in order to provide care to patients in the community. The trust scored each visit on units of time, (15 minutes). Visits, depending on the dependency and needs of the patients, were made up of one or several units of time. Staff working in rural areas were allocated less units of work, to account for the extra traveling time between patient visits.
- Some community nursing staff said it was not unusual to have more units if time allocated to them than the recommended number. Staff working in the Basingstoke community teams said they should have 22 allocated units of care and four unscheduled units each day. However, they said, staff sometimes had 40 planned units of activity allocated to them each day. They told us they had been working at over capacity for the last six months. Staff in the Alton community nursing team, said they should have 17 units of activity allocated to them each day, but often had 25 units allocated to them.

- Some community teams told us that if they ran out of time to complete all their patient visits, they passed the visits onto the out of hours GP service and reported them as an incident.
- Some community teams reported they had no problems with staffing.
- Some specialist nurse services, including the heart failure service, had seen an increase in referrals, which meant there were now insufficient numbers of staff to deliver the service. In these situations, the individual services developed and submitted business cases to increase the staff complement.
- Some services, including the specialist nurse and clinical services, told us a lack of administration staff meant clinical staff were carrying out administrative work. This affected the time they spent with patients. In some areas, there were inventive ways of using administrative staff across several specialties. This released clinical staff to carry out clinical work rather than administrative tasks.
- Staff working in outpatient and radiology clinics, reported no concerns with the numbers of staff.

Managing anticipated risks

- The trust had a business continuity plan. This identified risks to business continuity including loss of utilities such as gas, electricity and vehicle fuel, IT failures, lack of staff and loss of premises. The plans detailed actions staff and the trust needed to take to ensure continuity of the service in these instances.
- The trust had a winter resilience and cold weather plan. This included action staff and trust needed to take in the event of severe weather to ensure business continuity and the safety of patients and staff. The plan was informed by lessons learnt during previous episodes of severe weather conditions.

Are services effective?

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

We are not rating the trust on this inspection

- Staff delivered care and treatment that took account of national guidance such as the National Institute for Clinical Excellence (NICE). A programme of internal audits was followed to measure adherence to policies and national guidance and individual services monitored outcomes for their patients.
- Patients had their nutritional needs assessed. Relevant plans were developed and referrals made to appropriate healthcare professionals.
- Staff had access to learning and development opportunities. This included internal training and attendance of relevant national conferences.
- The service met the trust's target of 90% of staff having an annual appraisal.
- The trust was developing an intergraded way of working, with many areas having integrated community teams that included nursing and therapy staff. There were examples of staff working with staff from other organisations such as acute trusts, the ambulance trusts, social services and voluntary services.

However,

- Not all staff demonstrated a full understanding of the mental capacity act or their responsibility towards it.

Evidence based care and treatment

- Staff delivered care that took account of national guidance such as the National institute for Clinical Excellence (NICE) guidelines. We witnessed staff talking to patients' about the latest guidance and signposting them to information, such as wound care guidance.
- We spoke with specialist teams across the trust including tissue viability, early stroke rehabilitation, diabetes, heart failure, respiratory, multiple sclerosis and Parkinson disease teams. They used best practice guidance and NICE guidance to inform the care and service provided. For example, the early stroke rehabilitation team used an internationally recognised arm and hand exercise program for people following a stroke. Respiratory teams followed guidance by the

British Thoracic Society, the heart failure team followed guidance set out by the British Heart Foundation and physiotherapists followed the nationally recognised balance and safety class guidelines.

- Community staff working in stroke rehabilitation team agreed goals and pathways with patients and relatives at the start of treatment programmes. They monitored and regularly reviewed the treatment programmes. We witnessed staff made changes to the rehabilitation programmes to best meet the needs of patients.
- Patients with long term conditions, such a Parkinson's disease and multiple sclerosis, had their specialist care planned by specialist nurses. The nurses planned the care with the patient, taking into account guidance from the relevant specialist support organisations.

Nutrition and hydration

- Nurses assessed patients' nutrition and hydration status using the nationally recognised "Malnutrition Universal Screening Tool" (MUST). Where staff identified patients were at risk of malnutrition, they took appropriate actions. This included guidance to patients and their relatives, referral to community dieticians and nutritional service in hospitals, and referral to speech and language therapists.
- The trust was in the process of commencing an enteral feeding service for patients who could not eat and drink, but received their nutrition and fluid through tubes into their digestive system.
- The trust's diabetic service education packages for patients diagnosed with diabetes included input from the community dietetic service about healthy eating.

Technology and telemedicine

- The trust's website had information leaflets and links to national guidance and support organisations that patients and their relatives could access.
- The trust's electronic patient record system meant most staff could access patient's records from any location. However, not all services used this system fully. The

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diabetes service did not use the progress notes section, but uploaded their notes in a separate section of the system. This meant other staff had to be aware when they had referred a patient to the diabetic service, that details of the action taken following the referral and associated guidance might be located elsewhere in the record system. However, the electronic record system the diabetic service used, allowed them to access the acute hospital records so they could coordinate the care with the patient's diabetic medical consultant. This meant patients received joined up, seamless diabetic care and treatment.

- The trust did not routinely use telemedicine. Telemedicine is remote monitoring and advice for patients with long term conditions. The diabetic service provided opportunities for patients to submit their blood sugar levels on an electronic system. This allowed staff to monitor patients and advise patients about any changes they needed to make with their own management of their conditions.

Patient outcomes

- The trust carried out local internal audits, some of which involved the community adult services. All services used the trust's electronic monitoring tool to measure and compare outcomes for patients across the service.
- The occupational and physiotherapy teams in Havant carried out clinical audit using a recognised tool. This scored patients wellbeing before and after treatment. Staff said the most recent audit showed good outcomes for patients.
- The musculoskeletal physiotherapy service measured patients' pain before and after treatment to determine the effectiveness of the service for patients.
- Staff running 'steady and strong' classes told us they believed the classes had reduced ambulance calls to patients as a result of falls. However, they had not carried out any data analysis to evidence this.
- The care home nursing team based in Fareham, who provided training and support to local care homes, had reduced the number of ambulance calls and unnecessary visits to hospital for patients living in the local care homes.
- The service audited all procedures carried out on the Xray departments in community hospitals.

- Patients using the balance and safety classes described positive outcomes from the course. Comments included "I can do more than before", I can "get out alone" and I am "walking where I wasn't before". Others spoke about their increased confidence and how they could now manage walking without a walking aid.

Competent staff

- Staff told us there was good access to training, through the trust's training department.
- Staff used the trust's learning and development website to book on courses. Staff carried out a learning needs analysis to support applications for courses not provided by the trust. This included courses such as nurse practitioner courses, attendance at national conferences and for health care support workers funding and support to undertake nurse degree courses.
- All teams developed their own training schedule that ensured their staff had the skills to meet the needs of the patients they supported. We saw examples of training schedules displayed in team bases.
- Staff in community teams had lead roles, such as tissue viability, safeguarding, moving and handling or end of life care. They attended relevant training and attended meetings to support them with their lead roles. They provided support and advice to the rest of their team, to ensure care provided met national guidance and practices.
- Radiographers completed training to enable them to "hot" report xrays for minor injuries and the orthopaedic choices service.
- Staff told us they received supervision sessions six weekly and annual appraisals. Some staff were line managed by staff of other professions, for example, some therapists were line managed by nurse. However, a senior member of staff of the same profession always carried out appraisals. For example, physiotherapists received their supervision from a senior physiotherapist.
- Data provided by the trust showed over all the community services met the trust's target of 90% of all staff having an appraisal completed annually.

Are services effective?

- All new staff undertook a corporate and local induction programme. Staff told us they did not start delivering care in the community until they had completed all their competency assessments.
- There was a structured programme to supervise and upskill health care assistants who worked independently in the community. This included successfully completing competencies for the activities they carried out and reviews by community nurses for every third visit they carried out for a patient.
- Discussions with community nurses across the trust indicated there was no formal structure for high level assessment to further develop their role as a community nurse, once basic competencies had been completed.

Multi-disciplinary working and coordinated care pathways

- The service demonstrated commitment to multidisciplinary working in order to deliver coordinated care.
- The recent restructuring of the trust meant in most areas community services were managed within integrated teams. This meant, in these teams, there were staff of differing care disciplines, such as physiotherapists, occupational therapists, nurses and medical staff, within one community integrated team.
- In other areas, including Gosport and Havant there were separate community nursing and therapy teams. However, to support coordinated care, there was nursing and therapy staff attendance at the weekly multidisciplinary.
- We observed many examples of multidisciplinary working within the trust and with other health and social care providers.
- Community teams held multidisciplinary meetings to discuss and plan care and support for patients with complex needs and those in vulnerable circumstances. The meetings included community nurses, community occupational therapists, physiotherapists, and a social worker from the local authority and in some areas representation from the trust's specialist nurses, a local GP and the local NHS ambulance trust. At one meeting, the GP and paramedic told us they attended the multidisciplinary meetings voluntarily because they felt the sharing of information was beneficial to their delivery of patient care. The paramedic said the sharing of information made the ambulance service aware of the vulnerable patients in the community. In other areas, community nurses attended GP practice meetings and were piloting working in partnership with the practice nurses to promote coordinated care pathways for patients.
- Specialist nursing and multidisciplinary teams worked across the trust. Their roles varied depending on how the service was commissioned. Some, such as the tissue viability nursing team, provided support to community and inpatient staff and patients, to ensure all patients received the appropriate care and support. However, other teams, such as the diabetic service, only provided care and support directly to community patients attending diabetes clinics and education programmes.
- The respiratory specialist nurse in Basingstoke told us the team provided education and advice to other care teams as well as providing direct care to patients. They felt they had strong links with the local acute NHS trust. They worked with them to ensure patients had the correct equipment and support to manage their respiratory conditions when they were discharged home from hospital
- Specialist nurses in Basingstoke described an ethos of delivering patient centred care with clinicians of all disciplines working together to ensure patients received the care they needed. Examples included working with acute clinicians and social care services to share information so patients did not have to have repeated assessments. The multiple sclerosis nurse worked with the acute neurology clinicians at the local acute NHS trust and developed links with local Multiple Sclerosis Society day centres.
- Several community teams used 'care home books'. This was a diary held at the care home, which care home staff and the community team communicated to each other. Staff told us the practice of using this communication book was reducing unnecessary hospital visits for people living in care homes. Community teams provided care homes with tear boxes that held simple dressings and a pathway for simple wound care. This meant people living in care homes had

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simple wounds attended to promptly without having to wait for a community nurse visit. Care home staff recorded and reported to the community team, so visits could be planned to further assess and treat the wound.

- The service collaborated with third parties and the voluntary sector to support effective care for patients. Hampshire Fire and Rescue Service, Hampshire County Council and the trust were working in partnership to reduce falls in the elderly population with the introduction of falls prevention champions and friends. Part of this programme was the delivery of balance and safety classes by the trust followed by delivery of Safety through Exercise and Education Resilience by Hampshire fire and rescue service and 'steady and strong' classes run by Hampshire County Council.

Referral, transfer, discharge and transition

- Individual services and teams had clear referral criteria, designed to meet the needs of patients. There was evidence of teams referring patient's appropriately to services that best met their needs.
- Each area had a single point of access referral process, which managed referrals for nursing, therapy, crisis intervention and other services. Referrals were coordinated by either an administrator who entered them onto the electronic records system and were then reviewed by the senior clinician on duty who triaged and allocated them according to need. In other teams, a shift coordinator triaged referrals and allocated work to staff, according to the needs of patients. In other areas, a duty nurse and a therapist managed the referrals directly; triaging and allocating patients to the most appropriate healthcare professional in a timely manner that met their needs.
- Community teams in some areas, told us about problems encountered with referrals from local acute NHS trusts. They described incidents where patients were referred from the local acute trust, when they were not provided with full details about the patients' needs or the patient was discharged before they were fit to be discharged. The teams developed to support appropriate early discharges from hospital were working with the acute trusts to reduce these incidents.

Access to information

- Staff had difficulties in accessing patient information in a timely manner.
- The trust used an electronic patient record system. At the last inspection of community services, the trust had identified that not all staff used the electronic recording system efficiently and effectively. The trust attributed self-management issues, staff reluctance to use laptops in patient's homes, difficulties with connectivity in the community and the use of temporary staff as reasons why staff did not use the electronic record system effectively.
- We found staff still did not use the electronic patient record system effectively. All staff we spoke with reported challenges with using the electronic reporting system whilst visiting patients in their own homes. In some areas, there was poor connectivity to the internet, which meant staff had difficulties in accessing the 'live' electronic reporting system.
- The trust had acknowledged this difficulty. The trust provided 3G cards for staff to ensure connectivity when working in the community. The trust had invested in a 'store and forward' licence. This meant staff could download patients records at the office base, complete the records electronically offline at the patients location and then when they logged in on line at the office base, the notes automatically uploaded to the online record system.
- However, in practice there few staff used these resources. Most staff did not to use their laptops during home visits. They made records by hand in a diary or note pad and then entered the records onto the electronic record system when they returned to the office base. Staff told us this sometimes resulted in them sometimes completing patient records in non work time, either staying late at work, or completing the notes in the evening at home. A few staff told us it could be up to a week before they updated the electronic patient records.
- During the inspection, we shadowed a number of community visits. At no time during these visits did nursing staff use their laptops in the patients' home. The overwhelming reason staff gave for not using laptops was that they felt it was inappropriate and disrespectful to record on a laptop in a patient's home, as they would

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not always be making eye contact with the patient. However, they were still making paper records during the visit, during which time they would not have eye contact with the patient.

- The trust had identified challenges associated with accessing and sharing patient information between GP practices and social services. In response to this, and to support effective sharing of and access to patient information for all services, the trust was piloting access to the electronic record system used by GP practices in the New Forest areas. The trust was also in the process of developing a memorandum of understanding with social services for sharing records to improve communication about patients' needs. In the meantime, social work staff, who attended multidisciplinary meetings, accessed the social services records to provide information for the community care teams.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- At the previous inspection of community services for adults there were no concerns about consent, Mental Capacity Act or Deprivation of Liberty Safeguards. However, at this inspection processes for assessing the mental capacity of patients posed a risk of delays in care and treatment.
- Discussions with staff showed processes for carrying out mental capacity assessments were different across the community teams. In some teams, the nurse made an informal decision, discussed this with their team leader and then asked one of the older people's mental health nurses to carry out a mental capacity assessment for the patient. In other teams, nurses used a mental capacity assessment tool to assess a patient's capacity to make decisions. If that suggested the patient did not have capacity, they then asked an older people's mental nurses to carry out an assessment of their mental capacity. Some staff in some teams did not know if there was any documentation to support and guide them in making mental capacity assessments.
- It was unclear why community teams, who knew the patient, asked older people's mental health nurses to carry out mental capacity assessments rather than carrying out the assessment themselves. This posed a risk that care and treatment was delayed whilst waiting for a member of the older people's mental health team to assess the patient. There was also the risk that by the time the older persons mental health team visited the patient, the specific decision that capacity was needed for, was no longer required.
- Training about the Mental Capacity Act and associated Deprivation of Liberty Safeguards was included in the safeguarding adults level 2 training. Data provided by the trust showed 97% of staff had completed this training. However, some staff told us they had not received training about the Mental Capacity Act and associated Deprivation of Liberty Safeguards.
- During our observations of care we saw staff explaining procedures, giving patients opportunities to ask questions and seeking consent before providing care or treatment.

Are services caring?

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

We are not rating the trust for this inspection

- Across all teams, we saw staff focussed on doing their very best for patients and their families, despite the challenges posed in some areas due to staffing shortages.
- Staff used a respectful, compassionate and kind approach, which many patients and relatives commented positively about.
- Patients and their relatives were involved in making decisions about their care.
- In order to address patients emotional needs, staff spent time listened to their concerns and worries, where possible they signposted them to appropriate support services.

Compassionate care

- Staff provided compassionate care in all settings. We spoke with 92 patients and 26 carers or relatives. All said that staff provided a good and caring service.
- We found care and treatment of patients within the service was flexible and compassionate. Staff developed trusting relationships with patients and their carers or relatives. Throughout the inspection we witnessed patients were treated with compassion, dignity and respect. We observed staff communicated with patients in a respectful way. Staff maintained patient confidentiality when attending to their care needs.
- Staff were respectful of patients' wishes and concerns. They discussed their care with them and made it clear when they would receive their next visit.
- Most patients receiving treatment from the community services told us the nurses were very kind and considerate. One patient told us their nurse "saved the day" when they developed a condition and the nurse arranged for it to be treated promptly by the doctor. Examples of other comments made by patients included "Although busy, they never rush my treatment. We have a good banter whilst they are treating me", "They are all so nice, they will do anything for you", "Staff treat me as a person and listen to me" and " my privacy is respected and [I'm] treated with dignity."

- However, one patient told us that sometimes the community nurse did not arrive and when community nurses were in their home they were continually looking at their watches, giving an impression that they were rushed and just wanted to get away.
- Patients attending the outpatients department at Lymington New Forest Hospital told us "We select coming here because it is always a delight", "Nothing is too much trouble" and "Staff are very approachable and listen to me, treat me as an individual and not a number."
- Staff in multidisciplinary meetings demonstrated a caring attitude towards patients during their discussions.
- All patients and relatives we spoke with who received care and support from the specialist nursing teams and specialist stroke rehabilitation teams spoke positively about the care they received. They commented about the compassionate and caring nature of all staff.
- We observed staff treated patients and their relatives or carers with compassion. We saw staff had a good rapport with patients and their families.
- The trust took part in the NHS Friends and Family Test. Results for the NHS Friends and Family Test in January 2017 showed that 77.6% of patients would be extremely likely to recommend Southern Health community services to their friends or families. This was above the national average of 77.3%. The test showed that since November 2016 there had been an ongoing increase in the number of patients who would recommend the community services to friend and family members.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated they were involved in their care and treatment.
- Patients told us staff explained their treatment options and they were aware of what was happening with their care. Examples of comments included "the nurses are very good, they listen to questions and answer so we

Are services caring?

can understand”, “the doctor visits with the district nurse and I am involved in discussion and decisions” and “the doctor listened and gave a good and understandable answer.”

- We observed staff engaged with their patients, taking time to ensure they understood the choices they had about their care and support and reasons behind their treatments.
- We saw staff supported patients to be involved in their own care and maintain as much independence as possible.
- Diabetic services held dedicated courses for patients recently diagnosed with diabetes. These supported patients to understand their condition and how to best manage their condition.
- At an intravenous clinic (a clinic where staff administered intravenous injections or infusions to patients), we saw nurses supported a patient to prepare

their medicine, so they could maintain some control in their own care. The patient had previously been able to manage their intravenous injections independently at home.

Emotional support

- Throughout the inspection, we witnessed many examples of kindness towards patients and their relatives, by motivated staff. Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required and responding to their concerns. Comments included staff were “Polite and friendly, always sympathetic.”
- Many of the services provided by the trust resulted in social and emotional support for patients. Group education, as in the diabetic education programmes and the balance and safety classes, gave opportunity for patients to socialise and provide peer support to each other.

Are services responsive to people's needs?

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

We are not rating the trust for this inspection

- The trust worked with the local commissioning groups developed services to meet the needs of the local population.
- Individual teams developed initiatives to meet the needs of their local population.
- Most staff had completed equality and diversity training. Staff knew how to access translation and interpreter services.
- Most patients were happy with the timeliness of clinic and outpatient appointments,
- Staff took complaints seriously. They responded to complaints, and made changes in the service where complaint investigations identified improvements or changes were required.

However,

- Service delivery did not always support patients to access care in a timely manner. Effectiveness of the single point of access and triage process in some areas was adversely affected by availability of staff. In some areas staff shortages meant they could not always visit all their patients. In these situations, patients were referred to the out of hours doctor service.
- The trust had not assessed whether a night nursing service was required across the whole of the organisations.
- There were delays for some patients accessing outpatient clinics and services, with between 11% and 14% not having an appointment within the trust targets.

Planning and delivering services which meet people's needs

- Southern Health provided community services for adults across the whole of Hampshire except for Portsmouth city, Southampton city and the Isle of Wight, with different commissioners. The trust, therefore planned and delivered services differently in different localities, dependant on the commissioning arrangements. The service met regularly with the commissioners, to consider the local health needs and plan services.

- Staff told us about services, where the commissioned service was no longer sufficient to meet the demand of the service. The trust was having conversations with the relevant commissioners with the purpose of obtaining increased funding to increase the service to meet the demand.
- There were many ongoing challenges with the commissioned wheelchair provider from a private provider in the south of the county. There were significant delays, up to two years, for the provision of wheelchairs from this wheelchair provider for trust patients living in the south of Hampshire. Staff told us the trust had discussed these concerns with the commissioners, but there had been no improvement in the service.
- Individual teams developed initiatives to meet the needs of their local population. Within the community teams, there were initiatives to support social care services with the aim of improving the care patients received in care homes and reducing the requirement for hospital visits.
- The trust had identified care homes frequently contacted the ambulance service to convey patients to hospital, who could be effectively cared for in their own setting. In response a care home team consisting of community nursing staff, community occupational therapy staff, paramedics and administrative support was set up. The team provided support in the form of staff training, holistic assessments of patients' needs, prompt occupational therapy support, in order to reduce the number of calls to the ambulance service and reduce the number of patients conveyed to hospital.
- The diabetic service, in response to patient views, carried out patient courses over one day, rather than half days. However, the course content was the same across the trust, so if needed patients could two half day sessions at different locations.
- In response to perceived demand in the Havant, Fareham and Gosport area of the service, the service had analysed the demand on exiting twilight nursing service and had identified demand for the service over

Are services responsive to people's needs?

the present provision and beyond the present twilight hours. In response, there was an agreement for funding of twelve additional staff to extend the service as a night nursing service to 4am.

- However, there was not a night nursing service across all areas of the trust. Patients had to use the out of hours doctor system in their area or the NHS 111 service. The trust had not carried out a needs assessment for the service. The service being introduced in the Havant, Fareham and Gosport area was because of the initiative to the lead nurse in that area.
- The service had developed teams to support appropriate early discharges from hospital and to provide a rehabilitation and reablement service for patients at home. These services had different names and were at different stages of development in different areas of the trust. These services included an 'in reach' nurse based at the local acute trust, to assist the acute trust identify patients who could be discharged with the support of these teams.
- Petersfield hospital, Gosport War Memorial hospital and Lymington New Forest hospital had rapid assessment units. These provided rapid assessment, investigation, treatment and care for patients with a variety of medical conditions including deep vein thrombosis (DVT), cellulitis, transient ischaemic attack (TIA), frailty and rapid medical assessment. This meant these patients did not have to be admitted to hospital. The trust had developed protocols of referral from local acute hospitals, GP practices and the community teams to support appropriate referrals.
- An enteral feeding service had been commissioned to provide support to patients who received their nutrition and hydration through feeding tubes.

Equality and diversity

- Mandatory training for all staff included equality and diversity training.
- Translator services and interpretation services were available. Staff knew how to access them.
- All services we visited were accessible to patients using mobility aids by the use of ramps or lifts. Disabled parking was available at hospital and clinic sites.

- The stroke rehabilitation team based in Lymington, provided patients with rehabilitation exercise directions in large print.

Meeting the needs of people in vulnerable circumstances

- The service demonstrated commitment to meeting the needs of patients in vulnerable circumstances.
- The diabetic service delivered training and support to traveller communities in their own settings. The diabetic service delivered this, despite the fact the diabetic service was not commissioned to deliver services in the community, as the team identified the traveller communities were in vulnerable situation, as their culture did not support them to attend health service in clinics.

Access to the right care at the right time

- Service delivery did not always support patients to access care in a timely manner.
- Patients accessed community services through a single point of access for their area. In some areas referrals were taken by administration staff, who passed the referral onto the member of clinical staff in charge of the shift to triage and allocate. In other areas, a therapist and duty nurse received and triaged all and allocated the patient for a visit according to their needs. However, in areas that had staff shortages triage of patient referrals was a challenge, due to staff availability to carry out the role.
- Community staff were required to see patients with urgently referred from GPs or the local NHS ambulance trusts were required to be seen by community staff within two hours of the referral. Staff working in the Lymington integrated community team told us they were not able to identify how frequently this target was met. This was because staff did not always code urgent referrals correctly on the electronic recording system.
- Information provided by the trust showed that in April 2017, 22 out of 33 community teams visited patients with an urgent referral within two hours. Of the remaining 11 teams, seven teams saw patients with an urgent referral within four hours. Only three teams had an average waiting time of over two hours, the greatest being three hours and fifteen minutes.

Are services responsive to people's needs?

- Outpatient departments held waiting list meetings every Monday to review the lists in order to ensure patients were seen in a timely manner. Additional lists were sourced to address extended waiting lists. Eye clinics provided laser treatment were carried out at Lymington New Forest Hospital. To meet the demand and reduce waiting times for this treatment, laser eye clinics were being introduced at Romsey Community Hospital.
- The trust's target for patients to be seen by the community and specialist nursing teams was three weeks from initial referral. The target for patients to be seen by the community outpatient therapy teams was six weeks from initial referral. The trust monitored these waiting times. The CCGs had set the trust a target that 90% of patients receiving their first appointment within the waiting time targets. For April 2016, 80% of patients received their first appointment within the three or six week target. On average patients waited 2.4 weeks for their first appointment.
- Community nursing staff expressed concerns about patient's access to social care. They found that they increasingly had to provide social care for patients where packages of care could not be available. This meant that although they were ensuring patients received care at the right time, there was an impact on their availability to deliver community nursing care.
- Community nursing teams also described situations where GP services referred patients to them for home visits, when the patient could and was willing to visit the GP surgery for treatment. This affected the team's availability to attend to patient who could not leave their homes.
- Staff told us there were varied delivery times for equipment, depending on the urgency of the order. Staff reported there were delays at times with the provision of equipment. To ensure timely provision of equipment, staff tried to anticipate patient needs and ordered equipment before the patient required it.
- There were significant delays between ordering and delivery of wheelchairs and cushions from the private provider for patients in the south of Hampshire. Staff said it was not unusual for patients to wait two years for delivery of a bespoke wheelchair. This affected patients and the care and treatment staff could provide to patients. Some patients could not get out of their houses. Some used non bespoke wheelchairs, which led to incorrect posture and risk of development of pressure damage to their skin and for some this affected their breathing and swallowing. Staff were not assured, when the patient eventually received their wheelchair, that it would fit them, as their posture and size may have changed since initial measuring.
- The community adults care teams monitored and reported on the length of time patients waited for their first appointments. In the year May 2016 to April 2017, the service consistently failed to meet its standard waiting time of two weeks. During this period, the service monitoring report showed they failed to achieve the service standard for wait times by between 11% and 14% each month, with the service receiving 4,300 to 7,000 referrals each month. The average wait was one week, however the maximum wait times were significantly higher, varying from 51 weeks (January 2017) to 175 weeks (August 2016). A waiting time of over three weeks was classed as a breach of the waiting time standard.
- Most patients we spoke with were happy with the accessibility of the services. Patients receiving treatment from the community teams told us "I tell the nurses if I am going out and they work round it to still visit. I ring the office and the message is passed on", "It works well, when I need an extra visit I request one and they come straight away" and the "district nurses come after 4pm but before 8pm to fit it with our daily schedule."
- Patients attending outpatient's services described mixed experiences. Comments included "Wait time acceptable, appointment bookings work well", "Appointments good, no cancellations and wait time acceptable"; "referral long wait, would have been five months wait but GP referred again and waiting time was reduced to six weeks, but felt this was still too long" and "Appointment was cancelled but no reason given."
- The diabetic service was not commissioned to provide support to inpatients or provide support to inpatient and community staff who also supported patients with diabetes. This meant there was no specialist support for patients admitted to the community hospitals and general community staff could not use the diabetic team as an expert resource to support the provision of care to patients in the community.

Are services responsive to people's needs?

Learning from complaints and concerns

- Staff told us there were clear arrangements for the management of complaints. As part of their service, staff gave all patients information leaflets about how they could make a complaint about the service.
- Staff across all teams told us positive changes in culture and responding to incidents and complaints had been made since the last inspection. They told us the changes made by the trust in response to concerns identified in the mental health and learning disability service had been trust wide and included community services.
- All staff told us they tried to resolve any concerns and complaints at a local level. Staff told us as part of the complaints management process they always met with the complainant to ensure they understood their complaint and provide feedback following the investigation of the complaint. In one area, during band 6 development days, complainants were invited to attend and share their experiences and the affected it had on them.

Are services well-led?

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

We are not rating the trust for this inspection

- Most staff felt supported, listened to and well supported by their immediate line managers and the executive team.
- Each team and area was involved in delivering the trust's strategy and goals. Each team developed its own set of objectives that were in line with the trust's vision and strategy.
- There was a governance structure that fed from the different teams upwards into the executive board. The teams used recently introduced dashboards to monitor their performance and safety record, including performance with regard to complaints and incidents.

Leadership of this service

- The trust had recently reconfigured the management and business structure of their services in order to promote integrated working for their entire health care professionals. Community services for adults was located in the Integrated Services Division. This division was led by a divisional director supported by a divisional director of nursing and allied healthcare professionals, a deputy director with responsibility for transformation, a clinical chair and a deputy director with responsibility for delivery.
- The divisions were separated into three business units. These were southwest Hampshire, southeast Hampshire and north and mid Hampshire. Each of the business units had a clinical director and associate director of nursing and allied healthcare professionals.
- The business units were further split into geographical areas and the community hospitals. General managers supported by heads of nursing and allied healthcare professionals and clinical service directors led these areas.
- This meant that managers of several teams had recently changed and new leadership was being embedded into the running of the different services and teams. Each area had an integrated area matron who provided senior clinical leadership. Each team had a team leader, who provided local leadership and support.

- Most staff spoke highly of their local leadership. They felt they were supportive and were receptive to new ideas from staff.
- Some staff told us the reconfigured management structure resulted in the development of effective working relationships between the different professions. Specialist nurses based in the northern regions of the county spoke about how they felt part of a specialist nursing team. Previously they had felt isolated, not part of a team and had felt they lacked leadership and direction.
- However, some staff felt uncomfortable having line managers who were not of the same health care profession. For example, therapy staff were concerned about being line managed by nursing staff. Some therapy staff felt the leadership of the service and the trust was dominated by nurses and were worried there was no future management structure for therapists. However, in some areas, the integrated matron role was carried out by a therapist.
- Most staff said they believed the executive and middle management teams understood their concerns and the pressures they experienced their work, but this was not consistent across all teams.
- Most staff told us that visibility of the executive board had improved. They received regular updates from the interim chief executive officer and the divisional director and many staff commented their service had received visits from the interim chief executive officer and the divisional director. The interim chief executive officer held listening events across the trusts to listen to staff and answer questions, listen to their experiences, hear their ideas and concerns. Staff told us these were held in various locations, to enable staff attend them. Those staff who had attended a listening event, had confidence the interim chief executive officer listened to their views and concerns and considered them in the development of the service.

Are services well-led?

Service vision and strategy

- The trust's vision was "To provide high quality, safe services which improve the health, wellbeing and independence of the people we serve." This was supported by the goals "to improve outcomes, experience and value for money."
- The trust had a five year strategy, developed from their vision and goals. The strategy had three key aims; to provide the best possible care today, introduce new models of care to meet the needs of tomorrow and enable change.
- Each team had a "navigational map" consisting of a flotilla of boats that represented the eight key objectives, identified by the trust, required to deliver the strategy. The key objectives related to quality, access, money, better local care, better specialist care, people development, infrastructure and helping you to do your job.
- Each team developed its own set of objectives that were in line with the trust's vision and strategy using the navigational map that was known as the team's boat plan. The plans detailed the team's objectives; how they were going to achieve them and how they would measure they had been achieved.
- Most teams we spoke with told us the whole team was included in setting the team objectives. However, this was not the same for all teams. Staff in the community teams in Havant told us they had not been involved in the development of the team objectives and that the managers set them.

Governance, risk management and quality measurement

- Since the last inspection, the trust had revised its governance processes. The trust had introduced a new quality structure in April 2017, which they were embedding into the running of services. The new structure consisted of a Quality and Safety Committee and several Quality and Safety Assurance Groups.
- The trust had a system for the daily reporting of detailed clinical information. To support the daily reporting and analysis of this information, the trust introduced a business intelligence tool in September 2016. This provided staff with patient and team information in a

dashboard layout to help them manage their performance and identify trends, such as patients being readmitted to services a short time after discharge. Information entered onto and measured on the dashboards included incidents, complaints, waiting times, staff compliance with mandatory training, and staff recruitment and turnover. This was a new way of reporting and analysing the very large amounts of information created by the trust to produce useful information for staff to improve patient care.

- All services and teams entered information into the business intelligence tool and used the tool to monitor the quality and effectiveness of their services. Staff we spoke with told us they found the system easy to use and used the tool to monitor their performance and identify areas for improvement. Team leaders used the information provided by the tool during performance reviews with their managers.
- There was an incident reporting and risk management structure in the trust. There was a trust risk register, which had not yet been separated into the new business structure of the trust, but was separated into the previous east and west regions of the service. The risk registers detailed when risks were identified, what actions were already been taken to lessen the risk and future actions needed to further mitigate the risk. Detail in the risk registers showed staff reviewed the risks frequently. This included review of whether staff had completed the actions and whether the action had reduced or resolved the risk. Staff we had conversations with, knew what the risks were within their service and wider risks within the trust. They told us access to the risk register through the business intelligence tool meant they could continually monitor the risk register.
- However, it was noted, that the risk to patients in the south region of the county due to the poor provision of wheelchairs from a private provider was not detailed on the risk register. The trust did not monitor how many patients were affected by the poor provision of wheelchairs. The trust said they raised concerns about the wheelchair service with commissioners at contract quality reviews and at serious incident investigation closures panels.
- Across the trust, there was a structured governance meeting programme that included meetings at the executive level to local team meetings. Team leaders

Are services well-led?

showed us there was a standard agenda used by all teams to ensure team meetings included governance items, such as review of incidents, complaints, staffing concerns, staff training, review of the team's objectives and shared learning from incidents occurring in the trust. The introduction of the business intelligence tool enabled staff to access accurate data about topics for review at meetings.

- The structured meeting process supported sharing of information across the trust, including sharing of information between the executive board and local teams.
- We saw teams collated quality information about their services. This was held in quality folders. Where space allowed, some teams displayed their quality information on information boards in their base office. Information included monthly checks to ensure patient records were current and up to date, staff training and clinical supervision were up to date and review of caseloads and work management. Records of governance and team meetings, reviews of complaints, concerns and compliments, patient experience surveys and incident analysis were also included in the quality folder. All staff had access to the quality folder.
- A practice of peer reviews carried out by staff from other trust teams, assessed individual teams performance. Teams were rated as either outstanding, good, requires improvement or inadequate against the five areas of safe, effective, caring, responsive and well led. Teams developed and followed action plans to address issues identified in the peer reviews.

Culture within this service

- Most staff told us there was a positive culture and a very good supportive team working amongst staff. Staff spoke about the caring nature of their teams. This included bespoke support and training provided to members of staff who had lost confidence in specific skills. Staff described a supportive culture within their teams. Staff told us they liked going to work as they worked in good teams.
- We saw individual staff and teams received formalised acknowledgement and thanks from the senior management.

- Most staff and teams felt their managers and the executive team were now listening to their concerns, where as previously they had not felt listened to.
- Specialist nursing staff in the north area of the county, who had previously felt isolated, were now based together. They felt supported, able to voice concerns that were listened, to and received support to manage and resolve any concerns.
- Staff had access to free in house physiotherapy and external counselling services.
- The trust recognised innovation and exceptional practice by awarding staff and teams with 'star awards.'
- However, staff in one team, spoke about a lack of consultation with them about changes in the management structure of their service. This made them feel they were not valued by the trust. They told us they knew things were happening, but the consultation period had not been very long. They told us that despite the consultation period, they had not been made aware they would need to reapply for their jobs and they had only found this out in their supervision meetings. They were told it would be to their advantage to accept the changes.
- Staff in another team, described a previous culture of bullying in that team. They described the management of that team had been like a "closed shop, one rule for one and not for others." They said previous concerns raised by staff had not been listened to. However, following changes in the management structure, they believed the trust was now addressing these issues.
- Due to the nature of the service delivered, many staff worked alone. The trust had a lone working procedure, which provided guidance for staff about how to keep themselves safe whilst working on their own. This included code words to use during telephone conversations with colleagues to summon urgent assistance.
- Although community staff were allocated a group of patients to visit during the day, there was no allocated times for individual patient visits. There was no process for identifying the location of staff whilst they were carrying out community visits. This meant there was a potential risk of delays providing assistance if a staff member was unable to call for assistance.

Are services well-led?

Public engagement

- All areas had patient experience champions, whose role was to put the spotlight on patient experiences, to help inform and influence the development of services.
- The agenda for team and governance meetings, gave opportunity for patient stories and experiences. This was either as a presentation of a patient's experience from a member of staff, or a patient attending the meeting to describe their experiences. This helped staff understand how patients viewed the service, the impact the service had on the patients' wellbeing and helped them identify where improvements needed to be made.
- Staff told us all patients were given information about how to raise concerns, complaints and compliments about the service.
- Staffing working in the Gosport community team, told us their patients were very involved in the service, they had a strong voice and influenced how the service was delivered.

Staff engagement

- Staff received regular updates from the chief executive. These were emails giving information about changes and developments within the trust.
- Staff said they could contact the chief executive using "your voice." This gave staff a forum to raise issues and concerns with the chief executive. There were mixed views about whether the chief executive took note of the information they received through this forum, but overall most staff felt their views were considered. Some staff provided examples where changes had occurred in response to their contact with the chief executive. This included purpose built respiratory rehabilitation facilities where previously they had to deliver the service in corridors.
- Staff told us they had opportunity to attend executive road shows, to meet and have conversations with the executive team.
- Monthly team meetings provided opportunity for staff to engage with their immediate line managers.
- The trust took part in the National NHS staff survey. Results from the 2016 survey showed overall the trust scored better than similar trusts in relation to appraisals, staff not attending work when feeling unwell,

staff able to contribute towards improvements, effective use of patient feedback and reporting errors and incidents. Overall the trust scored below the national average in response to organisational and management interest in and action on the health and wellbeing of staff, staff reporting recent exposure to harassment, bullying or abuse, staff recommending the organisation as a place to work and the percentage of staff working extra hours. From the survey, the trust identified three key areas of improvement: improving the communications between senior managers and frontline staff, getting staff to be involved in decision making and ensuring staff are taken seriously if they raise a concern.

Innovation, improvement and sustainability

- The trust supported implementation of innovative ideas by individual members of staff, individual teams and the business units.
- The Gosport community nursing team had developed a tracker tool to monitor progress and contacts with other health care professionals for their patients who had a pressure ulcer or identified as at risk of developing a pressure ulcer.
- The tissue viability nursing team provided support to all areas. They provided a quick reference guide and mirror to community staff to aid early identification of pressure ulcers.
- Support to care homes provided by the residential care home service in Fareham, had reduced the number of ambulance calls and unnecessary visits to hospital for patients living in care homes.
- As a result of the success of the residential care home service, the community teams in Fareham and Gosport provided 'tear boxes' to local residential care homes. Tear boxes held wound dressings and a care pathway for simple wounds. This meant people living in care homes had wounds attended to promptly without having to wait for a community nurse visit.
- The dietetic team had identified a need to support patients in the community who received their nutrition and hydration enterally (via a tube into their digestive system). They were setting this up at the time of the inspection.

Are services well-led?

- The trust was continually looking at ways to improve the delivery of integrated care. They had restructured the leadership to support the establishment of integrated teams. This promoted closer working between different health care professionals.
- There were various trials across the trust to identify further changes that would support integrated working. In the Lymington area, staff were trialling accessing the electronic record system used by the local GP practices, to support effective sharing of information.
- The trust acted to support the local acute health services. Enhanced recovery at home services supported early discharge of patients from hospital who were suitable to receive treatment and rehabilitation services at their home. Many of the specialist nurses worked closely with the local acute trusts to provide 'joined up' care and support patients to remain at home.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

- Not all staff demonstrated a full understanding of the mental capacity act or their responsibility towards it.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity

Treatment of disease, disorder or injury

Regulation

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

- Storage of medicines in the intravenous clinic at Alton Hospital was not secure and some medicines had passed their expiry date.

This is a breach of Regulation 12 (1) and (2 e,g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

- Staff did not always recognise and escalate safeguarding concerns.

This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Delays in staff making entries in patients' records increased the risk of incorrect information being recorded.
- Care plans held at patients' homes were not up to date.
- Systems were not in place to ensure equipment (wheelchairs) were supplied by the service provider, ensuring that there was sufficient quantities to ensure the safety of the service user and to meet their needs

This is a breach of Regulation 17 (1) and (2 b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.