Dorset Healthcare University NHS Foundation Trust

RDY

Community health services for adults

Quality Report

Tel: 01202 303400
Website: www.dorsethealthcare.nhs.uk

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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)
RDYNM	Sentinel House		
RDYX4	Blandford Community Hospital		
RDYEJ	Bridport Community Hospital		
RDYFG	St Leonard's Community Hospital		
RDY22	Alderney Hospital		
RDY02	Kings Park Hospital		
RDYY2	Westhaven Hospital		
RDYX9	Westminster Memorial Hospital, Shaftsbury		
RDYFD	Wareham Hospital		

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall this core service was rated as 'good'. We found that community health services for adults were 'good' for effective ,caring, responsive and well led but 'required improvement' to be 'safe'.

Our key findings are:

- Process and procedures were followed to report incidents and monitor risks. Individual localities had quality dashboards which monitored safety information such as healthcare associated infections, avoidable pressure ulcers acquired in care, safety information related to workforce and patient experience Learning from risks, incidents, near misses was shared with staff.
- The environment was clean.Trust premises for community locations were well maintained. Equipment was available for patients in their homes and was usually delivered promptly Patients whose condition deteriorated were appropriately escalated and action was taken to ensure harm free care.
- There was a high vacancy rate for night nursing team staff. This team felt they were overworked with not enough capacity with one team to cover a very large geographical area.There were waiting lists for therapy and rehabilitation services due to staff shortages. The staffing across other teams were mostly safe.
- Care plans reviewed within district nursing teams were were not always person centred and did not demonstrate active involvement of the patients in risk assessments and goal planning.The information found in home notes was not always consistent. Staff told us that they did not receive any training or support on mobile working and it was not effective due to poor internet connectivity.
- Staff across all services described anticipated risks and how these were dealt with. Safeguarding protocols were in place and staff were familiar with these.
- Community services for adults took into account guidance from the National Institute for Health and Care Excellence (NICE). There was well established multidisciplinary team working across almost all the community services we visited, Staff had statutory and mandatory training, and described good access to professional development opportunities.
- Incidents of pressure ulcers varied throughout the period and a plan was in progress to reduce avoidable pressure ulcers.
- Discharges from the intermediate care and Integrated Community Rehabilitation teams ICRT were affected due to delays in transition to social care services for patients awaiting long term care package.Staff told us that these delays could sometimes be more than six weeks and this eventually affected the teams' ability to accept new referrals.
- Staff spent much of their time in trying to obtain accurate information about patients from referrers including GPs and acute hospitals.They said that often the important information such as patient's medical history, medication was not received and referral forms were not fully completed .
- Patient feedback was collected and used in planning many of the services we visited, most frequently through surveys or focus groups. Feedback from patient surveys was very positive. Lessons from incidents and complaints were usually shared within the staff.
- Patients received compassionate care that respected their privacy and dignity. Patients told us they felt involved in decision making about their care.We found staff were caring and compassionate. Without exception, patients we spoke with praised staff for their empathy, kindness and caring.
- There were effective governance arrangements and most of the staff felt supported by managers.The culture within community services was caring and supportive. Most staff were actively engaged and the service supported innovation and learning.
- Elements of the trust's vision and strategic forward plan had been implemented in community services. Staff were focused on achieving key outcomes and these were linked to the trust's vision and strategy.

Summary of findings

Background to the service

Dorset Healthcare University Foundation NHS Trust offers a range of acute and community services, and is the main provider of community services across Dorset.

The 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.

Adult community services includes:

- Community nursing, with a scaled down service at night.
- Community matrons
- Specialist nursing services.
- Integrated community rehabilitation services.
- Long term conditions therapyservices.
- Intermediate care.
- Pain service
- Chronic fatigue management service
- Community brain injury rehabilitation service
- Brain injury vocational service
- Musculoskeletal therapy service
- Dietetics service
- Stroke rehabilitation team

Community services work closely with acute services, commissioners, adult social care services and GPs.

Our inspection team

Our inspection team was led by:

Chair: Neil Carr, South Staffordshire and Shropshire Healthcare NHS Foundation Trust Chief Executive

Team Leader: Karen Bennet-Wilson, Head of Mental Health Inspections, Care Quality Commission

The team that inspected adult community healthcare services included CQC inspection managers and inspectors, as well as two experts by experience (people who use services) and a variety of specialists: community nurse, community matron,specialist older people's nurse, occupational therapist, physiotherapists, and a tissue viability nurse.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive NHS inspection programme.

How we carried out this inspection

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

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

Before visiting Dorset Healthcare University Foundation NHS Trust, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 23, 24, and 25 June 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Summary of findings

For this core service we visited a range of services including community nursing teams, community matrons, integrated community rehabilitation teams, long term conditions therapy team, intermediate car team, brain injury rehabilitation service, brain injury vocational service, wheelchair service, pain service, chronic fatigue management service, stroke rehabilitation service, balance group and pulmonary rehabilitation group, community and specialist dietetic service, leg ulcer clinic and musculoskeletal service.

During the visit we spoke with a range of staff who worked within the service, such as nurses, healthcare assistants, therapists and managers. We spoke with 85 staff. We spoke with 66 people who use services as well as carers and family members. We observed how people were being cared for and accompanied staff on eight home visits across the county. We reviewed 26 care or treatment records of people who use services.

What people who use the provider say

We spoke with 66 patients and relatives of patients covering all the adult community services we visited.We spoke with patients in clinics, at rehabilitation classes, by visiting them at home, and on the telephone. We received positive feedback from each person we spoke with. Patients and carers were pleased with the services they received and praised the professionalism of trust staff. They said staff were caring and supportive.

Patients and carers we spoke with felt involved in their care. They told us they were encouraged to set goals as part of their treatment plans and felt the goals they set were specific to their needs and circumstances.

Patients and relatives were positive about the care and treatment and said staff were, “Very caring and helpful.” One relative said that the “Nurses are lovely, really nice, and we look forward to them coming.” They described the service as “Excellent and responsive”.

Patients we spoke with told us of actions that had been taken as a result of risk assessment, for example, equipment they received at home, further advice or treatment, or referral to another service. They said the carers’ needs were also assessed and some patients could provide examples of care and support given to their carer as a result of such assessments.

Patients said they were given sufficient verbal and written information about their care and treatment. When they had questions, patients said staff answered these and provided clear explanations.

Good practice

- The pain service had undertaken research on a specialist pain management programme (PMP) conducted for patients living with fibromyalgia to help them deal with their condition from a position of confidence and empowerment. The team had been invited to present the research at various local and international events including development of Royal College of GP commissioning guidelines, development of the early pre-screening tool which was to be adopted by the faculty of pain at the Royal college of anaesthetists.
- Effective multidisciplinary working in intermediate care team and brain injury rehabilitation service which also involved input from voluntary care organisations consultants from Royal Bournemouth hospital.
- Staff were going an extra mile to support patients who could not access the services readily. Community nursing staff had provided services to patients in traveller sites, caravans and prison and on one occasion to a patient who lived in a tent in a geographically difficult location.
- The brain injury vocational service provided a range of rehabilitation activities for patients to practice and regain the confidence and essential skills. It held

different workshops such as job clubs, health for work, IT workshop, community outreach services. We observed a workshop where patients were participating in glass painting and sanding.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust MUST ensure

- There are sufficient numbers of suitably qualified staff in all community teams and ensure safe caseload levels; especially the night nursing team.
- Patients are protected against the risks of unsafe or inappropriate care and treatment arising from incomplete patient records or inability to access electronic patient records when required.
- Staff receive appropriate training and there is a formal process in place for staff to follow to meet requirements of the the Duty of Candour.

The trust SHOULD ensure

- Information about its referral criteria to community services is clarified and promoted.
- Community staff are engaged in developing policies and procedures and in service planning with commissioners, and are fully consulted about changes which affect them.

Dorset Healthcare University NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- Patient records were not always managed in a way that kept patients safe.Care plans reviewed within community nursing teams were not always person centred and did not demonstrate active involvement of the patients in risk assessments and goal planning. Generalised anxiety and depression assessments were not always completed.The information found in home notes was not consistent. Staff told us they spent long periods beyond their hours of work to complete records due to connectivity issues. This meant there were risks in delayed recording and incomplete electronic patient records.
- There was a high vacancy rate for the night nursing team and staff in this team felt they were overworked with not enough capacity, with one team to cover a very large geographical area.
- Most of the staff we spoke with told us they were up to date with mandatory and statutory training though the data provided by the trust showed that the compliance of staff completing the mandatory training varied a lot between various teams.
- Process and procedures were followed to report incidents and monitor risks. Individual localities had quality dashboards which monitored safety information such as healthcare associated infections, avoidable pressure ulcers acquired in care, safety information related to workforce and patient experience. Learning from risks, incidents, near misses was shared with staff. Staff described an ethos of openness and transparency in responding to incidents but were not aware of the additional requirements of the Duty of Candour in handling incidents.
- Infection control practices were followed. The environment and equipment were well maintained. Equipment was available for patients in their own homes and was usually delivered promptly. Staff were able to order urgent equipment such as pressure relieving equipment for patient use within four hours.

Requires improvement

Are services safe?

- Patients' health and well-being were discussed in detail in handovers and risks were identified. Frequency of visits was changed in response to findings. The teams responded to requests to assess deteriorating patients or patients' changing needs promptly.
- Staff across all services described anticipated risks and how these were dealt with. Safeguarding procedures were followed to protect vulnerable adults from abusive situations met. There were aware of the procedure for managing safety incidents including adverse weather and central alerting system (CAS) alerts.

Detailed findings

Safety performance

- The trust monitored safety thermometer data in relation to care provided to patients at home. The NHS safety thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls.
- Data provided by the trust covering the period March 2014 to March 2015 indicated the number of new pressure ulcers fluctuated throughout the year with the highest number reported in February 2015. Falls with harm saw an increase in April 2014, although the number of reported incidents fell after this.
- Between April 2014 and April 2015 community services within the trust reported 42 serious incidents through the National Reporting and Learning System (NRLS). Of these incidents, grade 3 and 4 pressure ulcers accounted for the highest number of incidents.
- Individual localities also had quality dashboards which monitored safety information such as healthcare associated infections, avoidable pressure ulcers acquired in the community , as well as safety information related to workforce and patient experience.
- The data from the quality dashboards were discussed at the locality and board level and service improvement plans were discussed with staff.

Incident reporting, learning and improvement

- The trust had systems in place to report and record safety incidents, near misses and allegations of abuse.
- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. They were able to give us examples of range of reportable incidents such as accidents, pressure ulcers, medication errors, slips ,trips and falls.
- All incidents were reviewed by the team lead and shared with the locality manager. Staff told us they tried to problem solve locally in response to incidents wherever appropriate. We were given an example of changing the position of a treatment couch following an incident in the pain clinic.
- Incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place and action plans were developed to reduce the risk of a similar incident reoccurring. For example, in response to high number of incidents related to pressure ulcers the trust had conducted pressure ulcer awareness training across various disciplines. Pressure ulcer care bundle and risk assessments were developed and access to a tissue viability nurse was made easier. Community nurses were given a laminated pocket card which outlined the management and suggested action plan for pressure ulcers.
- Most of the staff were able to explain how learning from incidents and complaints was cascaded to staff. Their responses indicated learning, and trends from incidents and complaints were disseminated to staff. Learning from incidents was discussed in staff meetings.
- Staff at the musculoskeletal clinic and a specialist nurse gave us two examples of incidents which were related to staff safety. They expressed a concern that there was no learning shared from these incidents and therefore lessons were not learnt.
- Learning from complaints and incidents were also shared across the trust via the route of trust bulletin; 'Quality Matters', and staff newsletter.
- Duty of Candour legislation requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a severe or moderate level of harm.
- Staff across all the services we visited were unfamiliar with the requirements of the Duty of Candour legislation. All staff who we spoke with understood the principles of openness and transparency that are encompassed by the Duty of Candour.Staff were aware of the importance of investigating incidents and

potential mistakes but were not aware that the Duty of Candour now made meeting the patient/family and sharing the findings of investigations a legal requirement.

Safeguarding

- Safeguarding procedures were clearly displayed on the walls in the clinics and community nursing offices we inspected.
- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. Staff were able to explain the types of concerns which would result in a safeguarding alert being raised and included concerns relating to children.
- Some locality teams had local safeguarding leads who they could access for support and who provided training in safeguarding, although not all staff we spoke with were aware of this.
- Staff told us they had received training in safeguarding vulnerable adults and children and were aware of the trust's safeguarding policy. There was, however, variable understanding of how to report concerns amongst some of the district nursing staff.
- Staff told us safeguarding concerns were reported as incidents and any concerns would be discussed in handover meetings and shared across the team.
- The percentages of staff who had completed the safeguarding training varied across the community services. For example; 100% of staff working in pain service and community matrons had completed the level two safeguarding training as of May 2015.The percentages of staff completing the same training was between 50% to 100% across the district nursing teams.

Medicines

- The district nurses did not carry any medicines except adrenaline (medicine that is used for anaphylactic shock treatment) which they obtained either from pharmacy or GP surgeries.
- Nurses told us there was a nurse prescribing formulary, which had been developed with the trust's pharmacy team, and this allowed those with appropriate training to prescribe medicines in a safe, consistent way.
- There were appropriate arrangements in place for the management of controlled drugs and medicines in patients' homes. This included individual stock checks and records of controlled drugs. We saw evidence of this in the patient records we reviewed.
- Staff who were not qualified to prescribe or administer medicines (for example, healthcare assistants and rehabilitation assistants) told us on home visits they sometimes prompted patients to take their medicines but did not give medicines.
- Community matrons told us that they had an access to educational programme on prescribing medicines which was run by 'non medical prescribing academy'. The staff were also able to access supervision sessions from the academy on a quarterly basis.

Environment and equipment

- Much of the equipment provided to patients for their own use was sourced from an external provider who was responsible for cleaning, servicing and delivering equipment to patients at home. Staff told us they were able to order equipment for patients when required and there was an electronic system for doing this. They also said that when they ordered equipment for urgent delivery, such as a pressure relieving mattress or a moving and handling equipment, the equipment was usually delivered within four hours. This was the case even at weekends.
- Staff were able to order mobility, daily living and moving and handling equipment by clearly prioritising them as either urgent or routine and they did not usually experience delays with deliveries. At some locations staff also had ready access to equipment stored at their base office, which included for example, commodes, walking frames and portable hoists.
- Staff gave us two examples of incidents where equipment had failed to be delivered or accessible in a timely manner in order to ensure patient safety in the past year. Staff told us that equipment safety issues were reported as incidents and they had also contacted the external provider directly.
- We observed the environment at the wheelchair services was segregated with each specific area of wheelchair assembly separate from another. The environment was very clean. The wheelchair

technicians told us that the wheelchair range had been standardised which meant that all components required were readily available in order to reduce delays for patients needing them.
- The portable appliance testing (PAT) was carried out on the equipment and they were serviced regularly.

Quality of records

- We sampled 26 electronic care records across different teams in multiple locations within community services. The quality of records varied across different teams. The services and teams we visited used a combination of paper and electronic patient record keeping systems. Some paper records were held in patients' homes and we saw these during our home visits with staff. A minimal set of paper notes were kept in the patients' home with key information recorded such as care plan, skin monitoring forms and consent forms. These were scanned into the computer when completed. However the information found on the paper notes was not consistent and there were no home notes on two patients we visited with the Wool community nursing service.
- The trust had introduced electronic recording system across all the community services except for the brain injury rehabilitation service which was using a different electronic recording system. Some of the staff told us that they did not receive adequate training to use the electronic recording system and overall found it difficult to find things such as risk assessments.
- Some of the care plans we reviewed within district nursing teams were basic and were not person centred. They did not demonstrate the active involvement of the patient in risk assessment and goal planning. Generalised anxiety and depression assessments were not always completed. Staff told us they were leaving these assessments for the patients to complete on their own, however, patients with complex and long term needs could be unable to complete these assessment without help.
- Patient records reviewed at the integrated community rehabilitation team, virtual ward, brain injury rehabilitation service and early supported stroke discharge team were very comprehensive. Records contained initial assessments including medical and social history, social situation, cognitive abilities, risk assessment, activities of daily living and emotional and psychological factors. Care plans were in place and goal attainment scale(GAS) was completed. We saw evidence of review of treatment. Records were up to date and information was objectively recorded and verbal consent to treatment was noted. Walsall pressure ulcer risk score had been consistently completed. We saw recorded evidence of good multi-disciplinary and multi-agency communication.
- Staff recognised the importance to keep the information up to date on the system. However they told us that due to connectivity problems and the time taken to complete records online they often spent time in the office at the end of a shift, or after days off, to complete records including incident records.

Cleanliness, infection control and hygiene

- We observed a high degree of compliance with hand hygiene, isolation procedures and the correct use of personal protective equipment (PPE), such as gloves and aprons. Staff adhered to the trust 'bare below the elbows' policy in clinics and home environments.
- Hand washing facilities and alcohol hand gel were available throughout the clinic areas. We observed most of the staff using portable hand gels before and after patient contact during home visits. An exception was on a home visit with integrated community rehabilitation team (ICRT) in Christchurch where we did not see evidence any hand hygiene practice even though staff carried the hand gel with them.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinics and home environments.
- Staff told us that they had completed infection control training, and were able to tell us about precautions taken to prevent and control the spread of infection in community. The percentages of staff who had completed the infection control training varied across the community services. The data provided by the trust demonstrated that in most of the community teams,100% of staff had completed the training as of May 2015. In community matrons and community nursing team across Bournemouth localities the compliance varied between 62% to 69%.
- The locations we inspected were clean, and with effective infection control measures in place.
- We observed that effective cleaning procedures were in place in wheelchair services at St. Leonard's hospital.

When a wheelchair was returned from a patient, it was brought into a 'cleaning chamber' where it was deep cleaned. It was then repainted and re-engineered before it was ready to be reissued .

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, communication, consent, complaints handling and information governance training. Staff told us they were up to date with their mandatory training. Staff received an electronic reminder when the training was due.
- The data provided by the trust showed us that the compliance with mandatory training varied across the community health services teams with some teams demonstrating higher compliance in completing mandatory training than others. The range of percentages of staff completing their mandatory training varied between 40% to 100%, with most of the teams achieving compliance between 90% to 100%.The compliance of completing mandatory training was particularly low in community nursing teams across Bournemouth and Poole localities**.**

Assessing and responding to patient risk

- Patients were given an individualised, multidisciplinary risk assessment regardless of the service they used. For example, patients had assessments as required for mobility, nutrition, pressure ulcers, mental and emotional wellness, occupational therapy and home environment. We saw evidence of this in almost all the patient records we looked at. Patients we spoke with told us of actions that had been taken as a result of risk assessment, for example, equipment they received at home, further advice or treatment, or referral to another service.
- We attended handover meetings at community nursing teams, intermediate care team, virtual ward round and a team meeting of brain injury rehabilitation service. We observed that patients' health and well-being were discussed in detail, and risks identified. The frequency of visits was changed in response to identified risks.
- The intermediate care team used the National Early Warning Score (NEWS), a scoring system that identifies patients at risk of their medical condition deteriorating or needing urgent review. Staff demonstrated awareness of the appropriate action to be taken if patients scored higher than expected. The completed NEWS charts we looked at showed that staff had escalated patients appropriately, and repeat observations were taken within the necessary time frames. The NEWS score was not used in any of the other services we visited and the trust had plans to roll it out to community nursing teams later in the year.
- Referrals to other teams were made appropriately when required, we saw documentary evidence of this inpatient records and also heard examples in team meetings. Staff knew how to access advice from colleagues and told us they could raise concerns about patients' wellbeing with their manager. For example; we heard discussions in community nursing handover about an elderly patient with long term conditions who was at high risk of falling. A referral was made to the therapy team and environmental check were carried out. The team leader had agreed to do a joint visit with the community nurse to do further risk assessment for this patient.
- Patient handover took place three times a day in the intermediate care team and once daily in the community nursing teams. Staff ensured that the patients' changing needs, risks and any changes made to their care arrangements were effectively communicated to staff coming on the next shift.
- Incidences of pressure ulcers were monitored and investigated. Where there was a deterioration in a pressure ulcer, the causes of this were reviewed and actions were put in place to prevent further deterioration and new occurrences. For example, in the community nursing handover, we heard discussions about the need to change the type of dressings and pressure mattress for a patient who had developed a grade 3 pressure ulcer. Patients with grade 3 and grade 4 pressure ulcers were also referred to the tissue viability nurse.
- Staff we spoke with said they had training in cardiopulmonary resuscitation (CPR) and were aware of procedures for getting assistance in an emergency.

Staffing levels and caseload

- The trust reported that the percentage of total vacancies for community services as of May 2015 was 9.29%.The total number vacancies for full time equivalent qualified nurses across all the community teams was 23.74 and that for the nursing assistants was 12. The staffing for community nurses varied across the different localities.

Requires improvement

Are services safe?

Some of the localities were fully staffed and the vacancies were advertised when identified. Most of the staff told us that that the vacancies or sicknesses were covered by bank or agency nurses. The data provided by the trust also showed that as of May 2015,all the vacant shifts were filled with bank or agency nurses to cover staff sickness, vacancies or absence.

- Most staff at all grades across community services we visited told us that the staffing levels felt sufficient and, although there were some vacancies, were managed effectively so they were providing safe care. Staff told us that the recruitment ;especially for the nurses had been very effective in the last six to eight months.
- Insufficient staffing was a particular concern for the Shaftsbury community nursing team and the trust wide night nursing team. Staff felt stretched at times, and staff had been working over their contracted hours. Staff working in the Shaftsbury community nursing team told us that patient acuity had increased in recent years and this had not been considered in establishing the staffing numbers. Lower staffing levels had an impact on completing patient records and training not being undertaken in a timely manner.
- The data provided by the trust showed us that the vacancy rate for night nursing was 20.3% and staff turnaround rate was 24% as of May 2015. Staff in this team felt they were overworked with not enough teams to cover a large geographical area. The night nursing team was based in St.Leonard's hospital which is in south east corner of the geographical area that the trust covers. The team worked across Bournemouth, Poole, North and West Dorset. Staff said that this sometimes impacted on quality of care they provided .For example the team reported they were late to administer medicines due to being held up on another visit.
- The trust did not take a structural approach to calculate required staffing levels for its community services. However, the locality managers recognised more work needed to be done to ensure appropriate staffing levels across all community services. The locality managers for Bournemouth and Poole told us that they were currently piloting the 'Demand and Capacity tool' for determining staffing levels for intermediate care team within their area. There were plans to use the same tool for community nursing services following the pilot and approval by the trust board.
- Although the therapy staff did not express particular concerns around staffing levels, there were long waiting lists for physiotherapy or occupational therapy input in long term conditions therapy team and ICRT. Managers and team leads were aware of this and told us they were developing a strategy to respond to the waiting list.

Managing anticipated risks

- Community teams had contingency plans in case of adverse weather conditions. Staff also received email alerts if there was a weather warning. Patients were categorised by need which ensured that in the event of a major disruption those requiring the most urgent care were prioritised.
- Staff told us that they had developed good links across the community services which enabled support to be given in case of adverse weather.
- The locality managers said they discussed any central alerting system (CAS) alerts at team meetings. The CAS provided safety critical information and guidance which could include equipment and medicines.
- Each location had a local risk register. The local risk registers identified the actions taken in each area, risks they were unable to address were escalated onto the corporate risk register. For example, the risks associated with lone working in community were identified on the corporate risk register. The risks were reviewed regularly and action plans were in place to mitigate the risks.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Staff provided care to patients based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines.
- Patient outcomes were monitored by individual services and information about these outcomes was included in the trust's clinical governance reports. Staff had access to specialist training courses and had appraisals, but clinical supervision for nurses was not well developed. Staff worked in multidisciplinary teams to coordinate patient care.
- Patients were consented appropriately and correctly. Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Tele-monitoring technology was used for remote monitoring of patients with long-term conditions. The large amount of patient monitoring data collected by using this technology had sometimes raised anxiety with patients leading to a demand for increased visits by nurses which were not always necessary.
- Patients at risk of malnutrition or dehydration were risk-assessed by appropriately trained and competent staff, and referrals to and assessments by dietitians or speech and language therapists were appropriately made.
- The trust had implemented tele-health technology for patients with long-term conditions. Tele-health was helping clinicians to monitor suitable patients, who had actively accepted and developed an improved understanding of the management of their long-term condition.
- Staff spent much of their time in trying to obtain accurate information about patients from referrers including GPs and acute hospitals. They said that often the important information such as patient's medical history, medication was not received and referral forms were not filled completely .
- Majority of patients were appropriately referred to their respective services. However, there were significant percentage of referrals were made inappropriately because referrers did not understand referral criteria.
- Discharges from the intermediate care and ICRT were affected due to delays in transition to social care services for patients awaiting long term care package. Staff told us that these delays could sometimes be more than six weeks and this eventually affected the teams' ability to accept new referrals.

Detailed findings

Evidence based care and treatment

- Staff provided care to patients based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines, and were aware of recent changes in guidance. We saw evidence of discussion on NICE guidelines in patients' health care records.
- We spoke with specialist teams across the trust including long term conditions, brain injury rehabilitation, speech and language therapy team, pain service and early supported discharge stroke service. These teams used best practice guidance to inform the care and services offered. For example, the early supported discharge team was established to promote early discharge of a patient with stroke from hospital by providing support from therapists. Patients received support for approximately six weeks, if required, to help them with their rehabilitation in their own home.
- There were integrated care pathways based on NICE guidance for stroke patients. There were specific pathways and protocols for a range of conditions, these included heart failure, diabetes and respiratory conditions. Staff were alerted to NICE guidance through the trust website and they considered it as an individual responsibility to keep themselves updated with this.
- Local policies such as the pressure ulcer prevention and management policy were written in line with national guidelines and staff we spoke with were aware of these policies. Patient records we reviewed showed risk assessments and care plans for patients who were at risk of developing pressure ulcers. During home visits, we observed nurses undertaking skin checks of bed-bound patients and providing advice and pressure relieving equipment to patients.

Good

Are services effective?

- Compliance of community services with NICE guidance was assessed and action plans were in place where services were non compliant or partially compliant. For example; in a compliance audit related to 'Falls in Older People; assessment after a fall and preventing further falls' guideline, the community services were fully compliant on two outcomes, partially compliant on three outcomes and was not commissioned for the one outcome out of six clinical outcomes. In response to this the service had developed an action plan, introduced robust risk assessment protocols and had increased awareness of management of falls amongst the staff.

Pain relief

- Patient's pain monitoring and recording varied across the community services. Staff in community nursing teams told us that they did not use pain assessment measures. We did not see records of pain assessments and monitoring in the patient records that we reviewed.
- In the intermediate care team, pain levels were scored using the National Early Warning Score (NEWS) chart. We heard discussions about reviewing pain medications of a palliative patient in the MDT. Staff had good knowledge of pain management which they recorded on patients' records. This ensured that patient's needs were being discussed and provided.
- ICRT used visual analogue scale to measure pain. The assessments of patient's needs including pain management were comprehensive. Patients were always asked if they were in pain, the type of pain and how they managed their pain as part of the initial assessment process.

Nutrition and hydration

- Patients' nutrition and hydration status was accurately assessed and recorded in the care plans.
- The 'Malnutrition Universal Screening Tool' (MUST) was used by the community nurses. There was a clear action plan for patients who were nutritionally at risk.
- Nutrition and swallowing assessment was carried out for patients suffering with stroke, by the Stroke Rehabilitation team, and patients identified with swallowing difficulties were referred to speech and language therapists.
- The patients who were nutritionally at risk were referred to community dietitians who were able to respond to urgent and routine needs. The dietitians were involved in training the community nurses and community matrons in nutritional assessment.
- We heard discussions about considering patients' choices regarding meals, meal preparation, and the provision of a freezer to store frozen meals during the virtual ward round that we attended.

Technology and telemedicine

- Tele-monitoring technology was used for remote monitoring of patients with long-term conditions such as chronic obstructive pulmonary disease (COPD) and heart failure. This was achieved through patient-recorded observations, such as pulse rate, blood pressure and oximetry, coupled with electronic responses to key questions.
- The trust had also implemented tele-health technology for patients with long-term conditions. Tele-health was helping clinicians to monitor suitable patients, who had actively accepted and developed an improved understanding of the management of their long-term condition. Patients and their carers were able to monitor and send observations electronically , these were regularly viewed by a clinician able to take action as necessary.
- Nursing staff told us that although the tele-health technology was well received by some of the patients, it had created some challenges. The large amount of patient monitoring data collected by using this technology had sometimes raised anxiety with patients leading to a demand for increased visits by nurses which were not always necessary.

Patient outcomes

- During 2014-2015,community teams were involved in national audits that they were eligible for. The early supported discharge team contributed to the Sentinel Stroke National Audit Programme (SSNAP).There is no national figure given for these audits. Each domain is given a performance level (level A best to E worst) and a key indicator score is calculated based on the average of the 10 domain levels for both patient-centred and team centred domains. For October 2014 to March 2015,the overall performance of the trust in SSNAP audit was

above the national average. The trust performed significantly above the national average in provision of physiotherapy, occupational therapy and speech and language therapy and goal setting for stroke patients.

- Intermediate care services participated in the National Intermediate Care Audit in 2014 and 2015.We were informed by the trust that the results were available at a national level and they did not get trust specific results for this audit. The trust was looking at how they could achieve the results of this audit so that any suggested improvements could be implemented.
- Data from the trust's quality account report for the period between 2014-2015 showed that the community teams had participated in internal audits such as falls prevention and management, NEWS, hand washing and care planning. Action plans were developed and implemented following the outcomes for these audits. For example, the staff at the brain injury rehabilitation team told us that they needed to improve on the documentation of patient outcomes and consent following the care plan audit. The team had introduced a checklist to remind staff on improving the documentation. We reviewed patient records and saw the implementation of the action plan. The team had plans to re audit the outcomes in three months' time.
- The trust did not undertake any audits to measure avoidable hospital admissions.
- Most of the services we visited measured patient outcomes as progress against individualised goals, which patients set for themselves with support from staff. This was done by assessing patients before and after treatment or rehabilitation, and measuring how much progress patients made between the two assessments. For example, the therapy teams such as long term conditions therapy team, stroke rehabilitation team, and integrated community rehabilitation team used goal attainment scale(GAS) to set goals with patients and monitor their progress against them. The patient records reviewed by us demonstrated the evidence of this.
- The pain service had undertaken research on a specialist pain management programme (PMP) conducted for patients living with fibromyalgia to help them deal with their condition from a position of confidence and empowerment. The service had regularly evaluated scores from PMPs over the period of one year and had arranged staff training in order to improve delivery and content. The team had been invited to present the research at various local and international events. They had also participated in the development of Royal College of GP commissioning guidelines, development of the early pre-screening tool which was to be adopted by the faculty of pain at the Royal college of anaesthetists.

Competent staff

- Staff told us they had regular annual appraisals. As of May 2015,96.9% of staff within adult community teams had completed an appraisal.
- Staff had access to specific training to ensure they were able to meet the needs of their patients. For example, staff at the pain service told us that learning needs were discussed at appraisal meetings and then within the team leaders group. It was expected that learning needs met both service and professional objectives. Staff had opportunities to attend conferences and other courses. Staff told us they felt they had the training to ensure they had the specialist skills required to offer specialist interventions.
- We were told by a therapist in the long term conditions team that they had recently completed a masters module in dementia from University of Bournemouth and there were plans to for them to act as a dementia lead within that service.
- The nursing staff from leg ulcer team attended a two day ulcer course which was competency based and included modules on application of compression and bandaging and performing vascular assessments. The nurses did not attend a refresher course, however their competencies were reviewed yearly through a self assessment form.
- The community nursing teams and community matron had input from the specialist nurses as an additional knowledge resource. The tissue viability nurses and dietitians had also provided training for community nursing teams.
- Staff felt that the trust offered them opportunities for professional development. We were given an example of a therapy assistant working in Shaftsbury ICRT being given an opportunity to undertake occupational therapy training by the trust at the local university.
- Most of the community nursing staff told us that they did not receive regular supervision. However staff were supervised clinically and felt that handovers and MDT

meetings provided them with learning opportunities. This meant that the nursing staff did not get a regular opportunity to reflect regularly on clinical practice and development needs.
- The staff in other disciplines in the community teams such as therapists, therapy assistants and community matrons told us that they received a regular and competency based supervision either in a form of peer supervision groups or one to one supervision with their manager.

Multi-disciplinary working and coordinated care pathways

- Staff felt that integration between community services and disciplines had improved in the last six to eight months. This allowed for improved coordination between community services and better management of patient care and treatment.
- Staff told us that multidisciplinary team (MDT) working across the trust was good. Staff felt able to consult with colleagues and there was good rapport with ward staff in bases in community hospitals. Specialist nurses were available to consult for advice on patient care. It was described by staff as a collaborative and supportive environment. Staff said they didn't feel isolated and worked within a supportive team.
- We attended multidisciplinary team meetings at intermediate care teams and a virtual ward meeting. The discussion was attended by professionals such as physiotherapists, occupational therapists, advanced nurse practitioners, student nurse , consultant geriatrician from Royal Bournemouth Hospital, psychologists, GP and a representative from 'Help and Care' voluntary organisation. The virtual ward meeting was also attended by health and social care coordinators. The staff present were able to make a constructive contribution to the meeting and focussed on identifying the patients' needs and treatment planning. The meeting considered active and new patients.
- We also attended multidisciplinary meeting at the brain injury rehabilitation service which was attended by physiotherapists, occupational therapists, psychologist and a neuro rehabilitation consultant (from Royal Bournemouth Hospital). There was a good understanding of the patients' individual care and treatment needs and how these could best be met. This led to productive discussions between the healthcare professionals attending the meeting. Staff identified that the input from a social worker in this MDT meeting would be valuable considering the long term complex social needs for patients using this service.
- Staff felt well supported by specialist nurses, and told us they could contact colleagues from other disciplines if they needed help or advice in a specific area.
- Staff described close working with local GPs. Community nurses and community matrons attended multidisciplinary agency group meetings led by and held at GP practices. Nurses told us attendance at these meetings was a good opportunity to share and receive information about patients, particularly those with complex needs. They said the meetings were used to prevent unnecessary admissions to hospital. The nursing staff also reported good links with other services such as the musculo-skeletal and rheumatology services.

Referral, transfer, discharge and transition

- The trust used single point of access (SPoA) arrangements to screen referrals into the service. Referrals were reviewed and forwarded to appropriate services from SPoA. The intention of this was to streamline the referral process which would result in patients receiving the care they needed more quickly. However, staff told us that referrals were not always received from SPoA and community teams received direct referrals from GPs, other healthcare professionals and referrals from patients themselves.
- Staff told us there were occasional instances of inappropriate discharge from acute services. The challenge, they felt, was in ensuring patients were discharged to the appropriate community team with completed discharge summaries and clear information about medication. We were given an example by ICRT of a patient discharged from an acute hospital who was at high risks of falls and in need of long term care. Although this patient would have benefited from a rehabilitation bed in a community hospital, they were discharged home with ICRT support due to the lack of a bed. Staff considered it as an inappropriate referral as the patient's safety was compromised. Staff had fed this back to the hospital and raised as an incident.
- Staff told us that majority of patients were appropriately referred to their respective services. However, they expressed frustration that a significant percentage of referrals were made inappropriately because referrers

did not understand referral criteria. Referrers included staff from the acute services. For example, patients who required long-term care were sometimes referred inappropriately to intermediate care who could only provide short-term care.

- Staff at ICRT (Christchurch) informed us that when facilitating a safe discharge to patients own home they were sometimes supporting/ providing care packages, as social services team were drawing out as soon as patient was identified with rehabilitation potential. This in turn affected the team's capacity to assess new patients.
- We were told referrals often did not include adequate information about patients' medicines. This meant nurses spent considerable time, calling GPs and doctors in order to clarify which medicines and dosages patients required. Staff felt more work needed to be done to ensure referrers understood what information was required to provide an effective referral, and what services are offered by community teams. Staff told us the effect of poor quality referrals put additional strain on services and delayed care for patients. However, we did not verify this during inspection.
- Community matrons and community nurses expressed concerns with the discharge procedures from local acute hospitals. On occasions, the community teams were not being informed when patients needed the support of community nurses. The hospitals had also failed to inform them about discharges of patients who had been on their case load for management of long term conditions. This had led to delay in receiving nursing care following patients' discharge.
- The ICRT in Dorchester was piloting an inreach service in Dorchester hospital since last eight months where staff from ICRT identified inpatients who were ready for discharge and arranged community care for these patients. The ICRT staff also carried out initial risk assessments and met with patients and families prior to their discharge. The staff told us that this had helped in reducing inappropriate discharges and the service had positive outcomes. This service was currently funded from ICRT budget however CCG funding had been applied for.
- Staff told us that the referral and transfer process between community services had improved in the last six to eight months as services integrated. Staff could refer a patient to specialist teams or to intermediate care if there was sudden increase in patients' needs. There were clear protocols for referrals and staff said these services were easily accessible.
- Discharges from the intermediate care and ICRT were delayed, as patients were waiting for the provision of a long term care package. Staff said that these delays could sometimes be more than six weeks and this affected the teams' ability to accept new referrals.
- In response to delays with transfer of a patient to social care, the trust had recently recruited two health and social care coordinators working across Bournemouth. Managers told us that these coordinators would to be supporting the 'Better Together' programme, the trust's initiative of bringing health, social and primary care services together. The coordinators were expected to support Intermediate care by pulling together multidisciplinary team meetings involving social care and by facilitating patient discharges that required care packages.

Access to information

- All of the community services, except the brain injury rehabilitation service, used the same electronic record keeping system to record information about patients. This had enabled the staff to access other teams' records after obtaining a consent to share.
- The record keeping systems used by the mental health teams, acute hospitals and some of the GP practices were not accessible, which meant that community services could not access information about patients held by these services and relied on the information in the referral.
- Nursing staff told us that much of their time was spent in trying to obtain accurate information about patients from referrers including GPs and acute hospitals. They said that often the important information such as patient's medical history, medication was not received and referral forms were not filled completely. They felt this was time they could not spend providing care to patients.
- A similar problem was faced by the staff when a patient was discharged from community hospital in the same trust. Staff from the ICRT told us that the inpatient therapy and nursing records were not always accessible for them. Occasionally, the therapist who treated the patient in community hospital followed the patient home with ICRT support. Although the same electronic

patient record system was used there were not access rights across the services to enable staff to view important information for effective clinical care. Staff found it frustrating not to be able to access patients' care plans and to have to liaise with hospital.

- Specialist nurses told us there was often only basic information on patient referrals and the information of concern that could affect staff safety as lone workers was not always highlighted. Examples of such information included a history of alcohol abuse, physical assault or any concerning mental health issues. Staff felt it could be unsafe to visit a new patient without this important information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment. Verbal consent to treatment was also recorded in all the patient records that we reviewed.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs).Staff had received mental capacity act training and various resources were available on trust intranet should staff need more support.
- We heard discussions in virtual ward meeting and brain injury rehabilitation MDT where mental capacity and legal issues were considered and addressed by staff and well supported by the mental health support worker and mental health lead. Staff demonstrated a good awareness of the mental capacity act, DOLs and consent.

Good

Are services caring?

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

Summary

- Patients and their relatives were treated by staff with compassion, dignity and respect. Feedback from patients and their relatives was continually positive about the way staff treated them. Patient and relative feedback strongly evidenced there was a caring and supportive culture in the community services. The results of the Friends and Family test in May 2015 demonstrated overall high satisfaction of the patients with community services
- Patients and relatives we spoke with said they were well informed and involved in the decision-making process regarding their treatment. The brain injury vocational service had introduced laughter yoga, ergonomics assessment, and fatigue management programme. Patients spoke highly about this service.
- Patient's emotional needs were highly valued by staff and were embedded in their care and treatment.
- During our inspection we observed that staff were responsive to patients' needs, and we witnessed multiple episodes of kindness from motivated staff towards patients across different community teams.

Detailed findings

Compassionate care

- We spoke with 60 patients and relatives of patients from clinics to visiting patients in their homes or contacting them by telephone. All patients we spoke with said that staff provided a good and caring service.
- We found the care and treatment of patients within all services was flexible, empathetic and compassionate. We found staff had developed trusting relationships with patients and their relatives.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed staff communicating with patients in a respectful way in all situations. Staff ensured confidentiality was maintained when attending to care needs.
- Patients told us "the staff are very caring and friendly and excellent" and staff responded quickly to their needs. We visited 12 patients in their homes with community nurses. All patients consulted were very positive about the nursing service and local healthcare. We saw evidence of a strong relationships with community nurses, a high level of trust and appreciation of support provided.
- On a home visit to a patient with leg ulcer we saw excellent holistic care including psycho-social care provided by a community nurse. The nurse demonstrated a good awareness of this patient's needs who was living with dementia. The nurse provided good support showing kindness and unhurried care.
- Staff in multidisciplinary meetings demonstrated knowledge, skill and a caring attitude towards patients during their discussions.
- In pulmonary rehabilitation clinic we observed a patient being treated with care, respect and dignity.
- The results of the Friends and Family test in May 2015 demonstrated overall high satisfaction of the patients with community services.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with stated that they felt involved in their care. Patients told us the staff had explained their treatment options to them, and they were aware of what was happening with their care.
- None of the patients we spoke with had any concerns with regard to the way they had been spoken to, and all were complimentary about the way they were treated.
- Patients told us about the assessment process and how this was used to inform discussions about their individual goals and progress in achieving them. The goals were written in user friendly language which encouraged the patient to take ownership of their own goals.
- Patients told us that the needs of carers were also assessed. Some provided examples of care and support given to them as a result of these assessments.
- We witnessed several examples of nurses and therapists explaining to patients and their relatives about care and treatment options and involving them in the care. For example, we observed a physiotherapist explain the suggested treatment and provide a detailed response to questions from the patient who was blind. The physiotherapist demonstrated evidence based practice

and excellent communication skills. The visit was very person centred and the staff worked with the patient to identify their goals and tailor exercises appropriately. The staff also discussed joint working and goal setting with the blind association who were planning a joint visit to assess the patient for a new mobility aid.

- The brain injury vocational service helped the patients to get back to work. The patients told us the staff gave them confidence and made sure they were 'fit to work'. The staff carried out visits to patients 'work places and also had discussions with their managers about patients' needs. The service had introduced laughter yoga, ergonomics assessment, fatigue management programme, and also undertook group interventions where they talked about anxiety management. Patients spoke highly about this service.
- We heard discussions in brain injury rehabilitation team's MDT meeting about setting up a gardening project to engage a patient who was suffering with neurological disorder. The team had involved a patient's parent in planning this project in their garden and help was obtained by a voluntary organisation.
- Patients said they were given sufficient verbal and written information about their care and treatment. They told us that when they had questions, staff answered providing clear explanations. For example, patients who had received treatment from pain service told us that they were provided with a pack that included educational information about coping with pain and answers to questions they may have. They told us that education about their condition had helped them to understand the affect of pain on their lives, this knowledge helped them live more independently. The pack included information based on four pillar model which focuses on learning about pain, building a healthy lifestyle, what matters to the person, developing emotional well being.

Emotional support

- During our inspection we observed that staff were responsive to patients' needs, and we witnessed many examples of kindness towards patients and their relatives, from well-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.
- When we accompanied staff on home visits, we found they treated patients with compassion and sensitivity. We observed staff asking patients how they had progressed since their last visit, and whether they had any concerns or required further support. We found staff had a good rapport with patients, and they appeared comfortable with the staff who visited them.
- The wheelchair service supported new wheelchair users by arranging them to meet other wheelchair users in similar circumstances. Staff told us that this helped the patients in overcoming resistance to the use of the wheelchair and helped them to gain assurance. They also ensured that patients could see wheelchair users playing sport to build their confidence and challenge perceptions of limitations.
- Community matrons offered support to patients who had a previous crisis and had not been in touch with a service for a while, ensuring support was continuous.
- Patients who had completed the pain management programme could continue to meet every six weeks for coffee. This provided them with peer support, emotional and social contact and allowed staff to observe how patients were coping with pain.

Good

Are services responsive to people's needs?

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

Summary

- There were good examples of staff and teams working responsively to reduce hospital admissions, and promote faster discharge. Intermediate care team and integrated community rehabilitation team (ICRT) acted quickly when patients needed support to initiate treatment and care packages. The trust was piloting a community phlebotomy service in collaboration with Poole Hospital NHS Foundation Trust to support housebound patients who could not visit the hospital for blood tests.
- Overall, community services were achieving the 18 week referral to treatment target. Intermediate care teams and ICRT were meeting their two hour referral to assessment target for rapid response rehabilitation between April 2014 to May 2015 and the community nursing teams were also meeting their target of contacting patients with urgent referrals within four hours.
- There were waiting lists for therapy-based services. The patients who were classified as having a low risk and non urgent needs, waited for a few weeks before they were seen.
- Support was available for patients living with dementia and patients with a learning disability. We were given examples of staff working closely with mental health teams and other support services to meet the needs of patients in vulnerable circumstances.
- Complaints were handled in line with the trust's policy and were dealt with in a timely manner. Staff were encouraged to be proactive in handling complaints. Staff received feedback from complaints in which they were involved. Patients we spoke with felt they would know how to complain if they needed to.

Detailed findings

Planning and delivering services which meet people's needs

- The integrated community rehabilitation team and intermediate care team offered a range of services dedicated to treating patients' requirements which included prevention of admission to hospital and the supported discharge service. The services were able to provide a range of different treatments ,nursing and therapeutic interventions which included a physiotherapy and falls service.
- The trust had identified a few nursing homes within Dorset which had higher rates of patients getting admitted to acute hospitals. This was done in collaboration with ambulance service as part of the'999 project'. Although community nursing teams were not commissioned to see patients in a nursing homes, the trust had stepped in as they have a duty of care. The trust had taken the initiative by sending community matrons to these homes to educate staff on the support available in the community that could help to prevent avoidable hospital admissions.
- The trust was piloting a community phlebotomy service in collaboration with Poole Hospital NHS Foundation Trust to support housebound patients who could not visit the hospital for blood tests. The service was funded through vacancy factor from the community nursing service and had started in April 2015.This was started as a three month pilot in Poole Bay and Poole Central locality and was further rolled out to Poole North locality. The locality managers told us that the service had already been very successful in terms of number of referrals from GPs who referred housebound patients to community nursing teams for routine and urgent blood tests. The service had also been well received by patients and staff. The service was able to respond flexibly to patient needs and urgent blood samples were taken the same day or within 24 hours, results were back with the GP by the end of the day. A full review of this service was due in July2015.
- Pain clinics were being extended to offer a more accessible service. Treatment times were adapted to allow patients to go to work and early evening appointments were offered.
- The long term conditions therapy team based at Alderney hospital conducted rehabilitation group activities such as pulmonary rehabilitation, stroke rehabilitation , balance, strength and exercise classes and upper limb group. We attended the pulmonary rehabilitation class and received positive feedback from

the patients. Patients told us that these groups had given them opportunities to build up confidence to cope with their conditions and were meeting their rehabilitation needs.

- The brain injury rehabilitation service had built a strong network and working relationship with small charities, vocational services and social services. Staff told us that as it was necessary to work with these services to meet the complex needs of patients with a brain injury. We heard discussions in the MDT which involved joined up working with voluntary organisations ,police and social services in order to meet the complex needs of a patient.
- The long term conditions therapy team had started a multidisciplinary falls clinic held at Alderney hospital since January 2015.The clinic was run by a consultant geriatrician, physiotherapist and an occupational therapist. Following assessment at the clinic, patients were either followed up in the community or were referred to balance, strength and exercise classes. The service was monitoring it's outcomes and had shown a reduction in numbers of domiciliary visits by therapists.
- The staff at the wheelchair service gave us an example of a change that they had made in the design of a wheelchair headrest following suggestions from patients with spinal injuries. The service had designed moulded headrests which offered better support and reduced the risk of developing pressure ulcers at the back of the head. This change had come through feedback from patients.
- Speciality nurses raised a concern of not having enough available premises in Dorset to run extra patient clinics. Tissue-viability nurses told us that they had waiting list for leg ulcer patients for clinics in Weymouth due to a lack of suitable venues.

Equality and diversity

- Mandatory training for all staff included relating to equality and diversity issues. A majority of staff had completed this training and were able to demonstrate an understanding of equality and diversity.
- Interpretation services were available and staff knew how to access this when needed.
- Staff were able support patients who could not access the services readily. Staff had provided services to patients in traveller sites, caravans and prison and on one occasion to a patient who lived in a tent in a geographically difficult location.
- All of the services we visited were accessible to patients using mobility aids by use of ramps and /or lifts. Disabled parking was available at the hospital and clinic sites we visited.

Meeting the needs of people in vulnerable circumstances

- The chronic fatigue service and pain services offered therapy and support in a variety of ways. The pain service had commissioned a website that had a user only area with secure log in so patients could share information and gain support from other patients suffering with pain. The chronic fatigue management service supported patients to go back to work or school by liaising and working closely with employer and schools to support the process. Occasionally the team also referred patients to vocational bodies.
- Patients living with dementia were referred to 'Memory Gateway Service' who carried out dementia screening and provided support to these patients. This service was run by Alzheimer's society who had won the contract to provide dementia services across Dorset.
- Staff told us that specialists could be contacted if support was required when working with patients with a learning disability - there was no barrier to referrals. Staff gave examples of working with patient with learning disability that included regular joint visits with colleagues from the community learning disability team.
- The wheelchair service worked closely with social workers to arrange accessible sporting activities; for example cricket, tennis, volleyball etc. We were given many examples of patients who were participating in sporting activities which encouraged their independence.

Access to the right care at the right time

- The trust was monitoring waiting times and referral to treatment times. The information provided by the trust for February 2015 ,showed, overall, community services were achieving the 18 week referral to treatment target. The wheelchair service had treated 92.8% of referrals within 18 weeks against the trust's target of 95%.
- Between April 2014 to March 2015,the community nursing teams were meeting their target of contacting patients with urgent referrals within four hours. The team also met their target for contacting patients with non urgent referrals within 24 hours in nine out of 12 months over the same period. Staff from community

Good

Are services responsive to people's needs?

nursing teams told us patients did not wait for treatment and that referrals were addressed promptly due the nature of their services. The patients we spoke with also told us that the nurses had attended them promptly and they did not have to wait for care.

- Intermediate care teams and ICRT were consistently meeting their two hour referral to assessment target for rapid response rehabilitation between April 2014 to May 2015.However, the waiting time for non urgent rehabilitation patients varied across other rehabilitation teams. We were told at the long term conditions therapy service that the therapists were risk assessing all the new referrals by telephone triage. The patients who were classified as having a low risk and non urgent needs, waited for a few weeks before they were seen. The service was monitoring waiting times. We examined waiting lists and found waiting times in some teams was over three months. Staff told us that this did not happen routinely and there were staffing concerns in the teams which were recently being addressed.
- Where patients were waiting for treatment, patients with urgent needs were prioritised. Staff described eligibility criteria and were able to explain the process for prioritising patients. For example, the staff at wheelchair services told us that they were able to prioritise referrals for end of life care patients and were able to assess and issue a wheelchair to these patients quickly.
- Community teams told us they responded to all referrals, even when they were short staffed, and that no patients were left without the care they needed. Patients we spoke with confirmed this and told us visits by community staff were rarely, if ever, missed.

Learning from complaints and concerns

- The community services monitored both complaints and concerns. The data provided by the trust for the year April 2014 to March 2015 listed 121 complaints in respect of community services for adults. The services had improved responsiveness by contacting the complainant soon after the complaint was received. This created a more personal approach to dealing with complaints. We were given an example of how the pain service responded to a large number of complaints by arranging a meeting with patients who had complained about the service and the team. This provided an opportunity to listen to the concerns of patients and explain the purpose and reasons for the treatment offered.
- Complaints were dealt with in a timely manner, and staff were encouraged to be proactive in handling complaints.
- Complaints were handled in line with trust policy, staff showed us that patients were given information on how to complain. The trust had a clear complaints process.
- Complaints leaflets were available at the entrance to clinic areas, and also in patient notes, where these were kept in patients' home. Most of the patients we spoke with felt they would know how to complain if they needed to.
- Staff told us that any learning from complaint investigations was shared with the team. The trust's monthly newsletter; 'Quality Matters' also shared lessons learnt from concerns and complaints across the trust.

Good

Are services well-led?

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

Summary

- The strategy for the community services was to integrate community and mental health services within Dorset area to provide seamless, joint care pathways for patients. Staff we spoke with were aware of the strategy and described integration and high quality patient care as key components of the trust's vision.
- There was an effective governance structure to manage risk and quality. Most of the staff felt supported by their managers. Staff were passionate to deliver quality care and an excellent patient experience. There were mixed views from staff about the visibility of the senior leadership team for the trust. The culture was caring and supportive. Staff were actively engaged and there was culture of innovation and learning.
- Specialist nurses felt that the managers were not able to spend much time with them and had a limited understanding of their role and the scope of their service. They had little involvement in service planning and engagement with commissioners.
- Patient feedback was collected and used in planning many of the services we visited. These included patient survey feedback and learning from complaints and more proactive work to gather views direct from patients receiving treatment from different community services.

Detailed findings

Service vision and strategy

- The service leads were clear about their priorities and had long term strategy for the community services. The trust's vision 'To lead and inspire through excellence, compassion and expertise in all we do' was embedded in community services. The service leads told us that the service strategy was to integrate community and mental health services within Dorset area to provide seamless, joint care pathways for patients. Managers were able to discuss this strategy and describe the challenges the trust had in implementing it.
- Staff we spoke with were aware of the strategy and described integration and high quality patient care as key components of the trust's vision.
- We found some elements in the strategy that related to community services had been or were being implemented. This included the development of a single access point for referrals, integrated community rehabilitation teams, community nurses working closely with GPs, therapy teams and mental health services.
- Staff were focused on achieving key outcomes and these were linked to the trust's vision and strategy. These included reducing unnecessary patient admissions to hospital, shortening patients' length of stay in hospital, and working towards integrated services.

Governance, risk management and quality measurement

- The community teams we visited had regular team meetings at which performance issues, incidents, concerns and complaints were discussed. Where staff were unable to attend team meetings, steps were taken to communicate key messages to them.
- The community services had a quality dashboard for each locality. It showed how the services performed against quality and performance targets. Staff told us that these were discussed at team meetings.
- The community services had a robust governance structure that went from team level to the trust board. The trust had a quarterly governance meeting where the results from clinical audit, incidents, complaints and patient feedback were shared. The locality managers had a monthly divisional management meeting where the outcomes of the quality dashboard and clinical governance committee were discussed. Minutes of these meetings showed that patient experience data was reviewed and monitored.
- The trust produced a monthly newsletter which was shared with staff. This included patient stories and lessons learnt.
- There was a local risk register which documented all known areas of risk identified across community services. The risk register also recorded action being taken to reduce the level of risk. The higher risks were escalated to the trust's risk register where they were reviewed by the trust's executive committee.

Good

Are services well-led?

Leadership of this service

- Each team or service had a team leader who provided day-to-day operational leadership. The team leads were managed by locality managers. Most staff told us their team leads and locality managers were supportive and would raise concerns on their behalf.
- The night nursing staff expressed a concern that management was not very supportive and they did not feel comfortable raising concerns with managers. Staff said that they felt like a 'a forgotten service'. The trust was aware of the leadership concerns within this team and had taken responsive actions to investigate the issues.
- There were mixed views from staff about the visibility of the senior leadership team for the trust. Many of the staff we spoke with knew the chief executive officer (CEO) and some teams told us they had been visited by the CEO. Generally staff felt that visibility of the board members had improved in the last six to eight months.
- There was an allied healthcare professional lead to represent these staff at trust board level. However, most of the therapists we spoke with did not know there was an allied healthcare professional lead.
- Band 6 and band 7 staff were encouraged to participate in a leadership training programme run by the trust. We came across examples of staff who had attended the leadership programme and found it beneficial.

Culture within this service

- The majority of staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.
- Front-line staff worked well together, and there was obvious respect between, not only the specialities, but across disciplines. We were told by a student nurse how they felt welcomed in Shaftsbury community nursing team where they had started placement six weeks ago. The student nurse said they felt very much part of the team and well supported by the team leader.
- There was a lone working policy to support staff working out in the community. There were arrangements for staff to follow including buddying, senior support and a central point of contact to telephone at the end of a shift. Personal equipment was available for staff including personal emergency alarms. Staff working evening or twilight shifts told us they worked in pairs for safety. All staff were issued with mobile phones. There were established code words for staff to use on mobile phone in the event of difficulty with a patient. Staff had completed the three yearly conflict resolution and breakaway training.
- The trust had recently identified staff who were at high, medium and low risk as lone workers by circulating the safety questionnaires. The trust had invested in issuing adapted identity cards (identicoms) and GPS devices for staff who were identified as high risk lone workers by July 2015.This included staff who worked out of hours. The trust had done this investment to support the staff in challenging situations. The trust had planned to train the staff on the new systems and support was going to be available before the staff being issued with the identicoms.

Public engagement

- There were examples of patients being closely involved in service development. These included patient survey feedback and learning from complaints and more proactive work to gather views direct from patients receiving treatment from different community services.
- Forums seeking the patient's view were held twice yearly by the long term conditions therapy team at Alderney Hospital and were aimed at obtaining feedback about the service from recently discharged patients and their carers. A report from the information collected at these forums was sent to the trust's patient experience facilitator. The feedback was also discussed in the team meeting and actions implemented for developing the service. We were given examples of changes made to the service as a result of patients' feedback.
- The pain service was undertaking a project for patients working alongside clinicians in delivering training. The service also had pain coaches (patients who had been through the programme and could support and mentor patients who were receiving treatment). Pain coaches were trained in this role and patients found their input very valuable.
- The wheelchair services patients were engaged through the wheelchair forum which was run by the trust through open membership.
- The brain injury rehabilitation service ran an 'information morning' for patients, carers and other healthcare professionals up to four times a year. We

Good

Are services well-led?

attended the information morning at Poole community health centre. It shared information about brain functions, thinking skills, fatigue, return to work following brain injury and also had peer support sessions from ex service users. The information was displayed in an innovative way for easier understanding for the public. For example; to explain the anatomy of the brain, a moulded brain shaped jelly was prepared by a member of the staff.

Staff engagement

- NHS staff survey results from 2014 showed the trust's performance was rated higher than or the same as the national average for staff believing the trust provided equal opportunities for promotion or career progression ,staff suffering work-related stress, staff experiencing discrimination at work, staff experiencing physical violence bullying, harassment or abuse from patients or relatives. Areas in which staff did not feel the trust performed well were raising concerns about getting support from immediate managers, job satisfaction and staff recommendation of the trust as a place to work or receive treatment.
- The trust was taking action to address the concerns identified in the staff survey by creating different opportunities to engage with staff. Information was sent to staff regularly by email and newsletter. Staff were encouraged to look at the staff intranet. Staff told us they had visited roadshows led by members of the executive team at Weymouth.
- The trust had recently introduced mobile working for staff who were issued with laptop computers. Staff told us that their views on mobile working were not sought and they did not receive any training or support on implementation. We did not see many staff using the laptops on the patient visits that we accompanied.
- Specialist nurses expressed a concern of not having much engagement with locality managers. They felt that the managers were not able to spend much time with them and had a limited understanding of their role and the scope of their services. Some specialist nurses said that they had little involvement in service planning and engagement with commissioners. They said that this had led to unrealistic expectations from clinical commissioning groups in terms of service delivery.

Innovation, improvement and sustainability

- The community service leaders told us that the trust had endorsed NHS England's 'Five year forward view' plan in improving sustainability and creating a new integrated model. The leaders did not think there were any financial constraints to the service and told us that the budget was available for recruiting staff and developing services.
- Innovation was encouraged from staff members across all disciplines. Staff said that some initiatives were in response to Government requirements such as falls and dementia strategies but they felt involved in such developments.
- Brain injury vocational service held different workshops for patients such as job clubs, health for work, IT workshop, community outreach services. We observed a workshop where patients were participating in glass painting and sanding.
- Brain injury rehabilitation service held a bimonthly table tennis group at the Poole Community Health Centre. We were told that there was a good participation from patients and this was aimed to improve hand-eye coordination, memory function and social bonding.

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	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: • Systems were not in place to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not sufficient numbers of staff in some community teams and the night nursing team, to meet the requirements set out in the fundamental standards. Regulation 18 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour How the regulation was not being met: There was not a formal process in place for staff to follow to meet the all the requirements of the regulation. Regulation 20 (1)