Leicestershire Partnership NHS Trust

RT5

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5YF	Hinckley and Bosworth Community Hospital	Community Health Services for Adults	LE10 3DA
RT5YG	Loughborough Hospital	Community Health Services for Adults	LE11 5JY
RT5YJ	Rutland Memorial Hospital	Community Health Services for Adults	LE15 6NT
RT596	Melton Mowbray Hospital	Community Health Services for Adults	LE13 1SJ

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We rated community health services for adults as requires improvement because

- The trust had not made sufficient progress in addressing the concerns raised at the previous inspection in March 2015. Following this inspection the trust were required to ensure teams were adequately staffed to prevent impacts on staff workload and ensure staff completed mandatory training in line with trust requirements.Insufficient progress had been made against these notices.
- The service had not delivered timely care to a significant number of patients. Service planning was not being managed in a systematic way. The high demand for services, high levels of staff sickness and staff vacancy rates had not been managed effectively. This had a negative impact on the delivery of urgent nursing care, continence services and non-urgent therapy care.
- Nursing staff had large caseloads. The number of visits was not always manageable. This impacted on the time available for staff development and training. In five of the six community nursing teams attendance on some mandatory training courses was below 70%.
- Staff morale in some teams was low, with high levels of stress. Some staff found there was insufficient time to complete their visits within the working day. There was limited time available for staff to attend specialist courses to enhance their knowledge.
- Data could not be relied upon to measure service performance or improvement.Data collection and interpretation did not include key pieces of information for example number of delayed or missed visits. The electronic data held by the trust was currently being validated with large numbers of visit records not closed on the database.
- The services did not have a strategy and there were no service plans. There was no process in place for learning from other organisations which provided similar services or to share this service's best practice.

However:

- Patients were happy with the care they received and were very complimentary about the staff who cared for them. We observed care being delivered in a kind and caring way, by staff who demonstrated compassion and experience.
- Care and treatment was planned and delivered in line with evidence based guidance and standards, and systems were in place to ensure trust policies reflectedthe latest guidance
- The single point of access made contacting the service easy for both patients and health professionals and enabled referrals into the service to be triaged and assigned from one central point.
- The integrated therapy and nursing teams and the primary care coordinators in conjunction with the night service had clear focus on keeping patients safe and well in their own homes.
- Complaints were well managed to ensure a timely response and aid learning.

Summary of findings

Background to the service

Leicester Partnership Trust (LPT) provides community health services to over one million people across Leicester City, Leicestershire and Rutland. Just under one third live in Leicester City and approximately four percent live in Rutland.

The community health services for adults, is part of the community health services directorate and provides community nursing services, including specialist respiratory and heart failure nurses, community therapy services including rehabilitation and a falls prevention services. These are provided by teams of occupational therapy and physiotherapists, a county wide podiatry service and speech and language therapy are also available.

The majority of patients cared for by community health services are over 65 years of age. Services provide care and support to help patients stay well and prevent future problems, support them to live at home and provide treatment when they are ill to help them recover.

Community health services are delivered from a wide range of locations including trust premises and third party locations delivering services to local communities. In Rutland health services are delivered in partnership with the local authority where there is an integrated model of health and social care being delivered.

Community nursing teams are located throughout the city and county areas with the three main areas being the city, the east and the west. Each area has planned visit teams which provide scheduled care and unscheduled care teams. The unscheduled teams or intensive community support teams provide care in 256 virtual beds across the whole LPT area. This team provides up to ten days (in principal) of intensive community nursing care and rehabilitation often for patients discharged from hospital who are not yet fully independent.

In conjunction with these teams is a Leicester, Leicestershire and Rutland night service unit, this is centrally coordinated from a city location. The team can provide care all night for up to four patients in their own home. The team also made visits to patients through the night in their own homes. This care varied from medication administration to a safe and well check.

Primary care coordinators employed by the trust are located in local trust hospitals to identify, assess and where appropriate facilitate the timely discharge of patients back into their own home with community support or to a local community hospital.

This service had been previously inspected as part of a comprehensive inspection in March 2015, when we rated the community health service for adults as good. This inspection was part of a wider trust follow up inspection.

As part of the inspection we visited locations where community nursing teams were based including health centres and community hospitals. We accompanied nurses on visits to patient homes both in the day and with the night service. We spoke with patients and their relatives and we reviewed patient care records.

We rated the community health services for adults as requires improvement.

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (Mental Health) CQC

Inspection Managers: Sarah Duncanson, (Mental Health) and Helen Vine (Community Health Services).

The team that inspected this core service included CQC inspectors and a variety of specialists: Community Matron, Physiotherapist, Occupational Therapist and Advanced Nurse Practitioner.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, 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 to the trust on the 7 November 2016. During the visit we held focus groups with a range of staff who worked in the service, such as nurses, health visitors and therapists.

During the inspection from 14 to 18 November 2016 we talked with people who use services. We observed how people were being cared for in their homes and during clinic appointments. We observed group therapy sessions. We talked with carers and/or family members and reviewed care or treatment records of people who use services.

We also attended multidisciplinary team meetings, patient handovers and focus groups.

During the inspection we spoke with 80 staff members, 29 patients and 5 relatives. We also reviewed 9 records of patients care.

What people who use the provider say

Patients told us they were happy with the service and the care they had received. They commented on their care making improvements to their health and felt they were informed about the care they had received.

Patients visiting outpatient community clinics explained they had received letters before their appointment date which explained all they needed to know to attend the clinic. During clinic appointments staff thanked the staff for the care they had received and were positive about returning for future visits.

Patients attending group therapy sessions spoke of being nervous before their first appointment but had found the sessions positive and the staff made them feel comfortable.

Patients spoke of staff being welcoming and supportive and were pleased that some of the exercises they were shown had been tailored so they could continue with them at home.

Good practice

A six week pilot of joint working between Leicester Partnership Trust intensive community support team and the local authority's home care assessment enablement team (HART). A HART team had been co located with an intensive community support team at Loughborough Hospital team base. This had enabled the HART team, who helped to coordinate social care services to be more involved in the discharge planning of patient care.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must make sure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure that actions are taken to address the failure to meet the targets for delivery of services, in particular the two hour response target for unscheduled care, and referrals for continence services, musculoskeletal physiotherapy and community therapy.

Action the provider COULD take to improve

- The trust should consider how to ensure daily caseload levels for community nursing staff are manageable and staff are able to access additional training relevant to their role.
- The trust should ensure that all premises where care and treatment are delivered are suitable and safe for that purpose and where health and safety risk assessments highlight concerns, these are assessed for their degree of impact and any required actions taken to address those concerns.
- The trust should ensure that emergency resuscitation equipment is made immediately available for patients receiving care and treatment.
- The trust should formalise the process for ensuring services are delivered to equally meet the needs of the diverse population to which they are delivered.
- The trust should consider developing a documented strategy and service plans to enable progress to be measured against set service development targets.

Leicestershire Partnership NHS Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safe as good because:

- Staff had a good understanding of the incident reporting process, actual incidents and near misses had been reported from teams across all areas, serious incident investigations were comprehensive and learning from incidents was shared. Being open and honest with relatives was an integral part of the incident reporting process.
- Staff had a good understanding of safeguarding and they were able to discuss and describe how they would act if they suspected someone was at risk of harm or abuse.
- Patient records were kept up to date with the care that was delivered. Records were stored securely and electronic records were protected from unauthorised access.
- All staff complied with infection prevention and control procedures. Waste was managed appropriately and clinic environments were suitable for the purpose for which they were used.
- There were established systems in place to identify and minimise risks, patient assessments were completed using recognised assessment tools.
- Therapy and podiatry services course completion rates were good. However, mandatory training rates were variable across the nursing teams.

However:

- The therapy rehabilitation unit at Hinckley did not have a defibrillator in the unit for staff to use in an emergency despite staff having been trained how to use one. Staff could access to defibrillator that was located on other wards and departments.
- The environment at the therapy rehabilitation unit at Hinckley posed a potential infection control hazard as peeling paint had exposed bricks which made it difficult keep clean.

Good

Are services safe?

- Although staffing levels were reviewed on a weekly and daily basis, vacancies and staff sickness were such that cover could not always be provided by bank and agency staff. This increased the number of planned visits to unmanageable levels.
- Bank staff and some community nursing teams had not attended key mandatory training courses, for example training on the Mental Capacity Act.

Safety performance

- The NHS Safety Thermometer measures a monthly snapshot of areas of harm including falls and pressure ulcers. The trust reported 286 new pressure ulcers during the previous 12 months. (Average of 23.83 per month). The highest monthly prevalence rate during the 12-month period was October 2015 at 1.24%.
- The trust reported 40 falls with harm during the time specified. The highest rate reported was 0.29% which occurred in March 2016. The prevalence rate was at its lowest in April 2016 at 0%.
- The trust reported 58 catheter and new urinary tract infection cases in the time specified. The highest prevalence rate recorded was in May 2016 with 0.37%.
- For the same date range, the trust also recorded 27,294 cases of 'Harm Free' care, with a mean of 2327 cases per month. The trust saw their best performance in July 2016 recording a prevalence rate of 97.14%.

Incident reporting, learning and improvement

- Staff reported incidents via the on line reporting system. All staff we spoke with understood how to report incidents and gave examples of where incidents had been reported. We observed a staff meeting where staff were reminded to report incidents and reviewed other meeting minutes were incidents had been discussed and learning had been shared.
- Data supplied by the trust showed near miss incidents were reported by staff. A near miss incident
- The community health services for adults teams reported six incidents to the strategic executive information system (STEIS) between October 2015 and September 2016, which was 7.7% of total trust incidents (78).
- The majority (four) of the STEIS incidents concerned reporting pressure ulcers. There was delay in treatment and one incident where confidential information was lost. We reviewed the investigation reports for these four incidents.The final investigation reports were comprehensive and actions were identified where learning could be shared. We saw action plans which showed the service was taking action. However, one incident highlighted where previous learning from a similar incident within the trust had not led to a change in practice.
- In two community nursing team base locations we saw clearly displayed information about the number of pressure sores. This made information readily available to staff and ensured the team was focused on this area of care.
- The trust gave staff smart phones so photos could be taken of any pressure area damage. Pictures enabled specialist advice from senior staff or tissue viability nurses to be obtained quicker and treatment to be started earlier.
- Teams shared learning as one senior member of staff explained following an incident for example, a pressure sore. The staff involved presented the incident to a fortnightly incident meeting. For a pressure ulcer incident the tissue viability specialist nurse attended and the operational manager.This was to enable the staff involved in the incident to be involved in the incident review and learning process. A senior member of staff at the meeting took responsibility for sharing the learning to the wider team at the next team meeting.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support for that person. There were varying degrees of knowledge about the term duty of candour. However, all staff had a good understanding of the principles of being open and honest when something went wrong. Some staff had received information about duty of candour as part of mandatory training they had attended.
- The trust's incident reporting system included a section within each incident report template to record contact

with patients/relatives and carers. A trust wide audit was completed during June 2016, this reviewed incident records to establish if the duty of candour process had been applied correctly. The report highlighted a better understanding by staff of the principles of the duty of candour and relatives had been informed of the incidents in all 27 incident reports reviewed. Areas for improvement had been identified to improve the recording of action taken under the duty of candour principles and a re audit was planned for January 2017.

Safeguarding

- The trust had a safeguarding policy and safeguarding training was part of the trust's mandatory training programme. From data supplied by the trust for the end of September 2016 showed, 80.7% of staff had attended their safeguarding adults training and 76.3 % attended their children's safeguarding level two training.
- The trust was a member of Leicester City and Leicestershire and Rutland local safeguarding children and adult boards. The trust's safeguarding declaration, which explained service users' rights with regards to safeguarding, including co-ordinated work by all agencies to ensure a holistic person centred response, was published on their website.
- From October 2015 to September 2016 there had been one safeguarding notification reported to the Care Quality Commission regarding community health services for adults. This was reported in June 2016 and related to the timeliness of a patient receiving the care they needed. We looked at the trust's investigation report of this safeguarding referral. The cause of the incident and learning had been identified.
- Staff we spoke with understood their safeguarding responsibilities and were able to discuss when they would need to raise a safeguarding alert. The examples included placing a patient in a place of safety after a concern for their safety was raised.

Medicines

- The trust had a medicines management policy which provided the procedure for the prescribing and administration of medicines. This was accessible to staff via the trust intranet.
- There were advanced nurse practitioners, some specialist nurses and community matrons who were non-medical prescribers. Non-medical prescribers are health professionals who have undergone additional training and are qualified to prescribe medication. This meant patients did not have to wait to see their GP to have changes to existing prescriptions or new medication prescribed. A senior member of staff explained staff who were leaders within the community nursing teams were encouraged to complete the training to become prescribers.
- We accompanied an advanced nurse practitioner on a visit to a patient's home. They assessed the patient's condition, and reviewed the timings and nature of the patients' medication. They documented this in the patient's electronic health record to ensure any effects of this change were monitored and recorded.
- We spoke with community nurses from all the areas of the community covered by the trust. They were consistent in their management of patient medicines. Nursing staff did not routinely transport patient medicines, patients' families were asked to collect medicines or local pharmacies delivered them to the patients' homes.We viewed the trust's controlled drugs policy, which confirmed the transportation of patient's medication should only take place in unavoidable circumstances, and a direct journey should be made to the patient's home.Community nurses confirmed this was what happened.
- Community health services nursing teams reported 116 medicines incidents from March to August 2016. The most common (52) incidents were where a dose of medication had been omitted, other incidents included where nurses had identified where a wrong dose had been prescribed. The trust had effective systems in place to investigate incidents including any prescribing errors.
- Patient group directives (PGDs) provide a legal framework that allows some registered health professionals to supply and administer specified medicines to a pre-defined group of patients, without them having to see a doctor. There were PGDs in place for specified medicines for both registered nurses and podiatrists.

Environment and equipment

Good

Are services safe?

- We checked equipment at the rehabilitation therapy unit at Hinckley and found the equipment was serviced, electrical safety testing had been completed and dates for future planned maintenance were displayed.
- Staff attended moving and handling training as part of their mandatory training programme, course attendance rates were above the trust target of 85% for all community teams.
- We saw the storage room at one community nurse team base location, the area was tidy and uncluttered, sterile packaged items were sealed and access to the room was controlled.
- Rooms where outpatient clinics were held were clearly signposted. Clinic rooms provided privacy and sufficient space for the clinics that were held. We observed a physiotherapy group exercise session. Equipment was provided for patient use, instruction was given to ensure patients remained safe while using the equipment and the environment was spacious and suitable for the session.
- We noted there was no defibrillator for use in an emergency in the rehabilitation therapy unit at Hinckley. There was clear instructions displayed and staff confirmed if a patient became unwell they called 999. Staff had received training on the using a defibrillator as part of their life support training. We raised this at the time of inspection. Following the inspection the trust confirmed the procedure was to call 999, and that a defibrillator was available from the adjacent hospital on the site. However, this defibrillator was not immediately available in the therapy unit building.
- The therapy unit was within a building owned by the trust. We noted in one patient area the paint was peeling off the wall in several places. This had caused bare brick to be exposed. We raised this at the time of inspection, staff explained this had been an ongoing problem and although patients used the area it was not in daily use. The trust had carried out a health and safety risk assessment of the site in June 2016. This had identified the buildings were old, not fit for purpose and were in a poor state of repair and the windows in the therapy block let in water. There was no documented assessment of the severity or likely impact of these findings and the attached action plan was not completed.
- The trust had carried out an infection prevention and control audit of the area early in November 2016 and a re audit following our inspection. On both occasions there were no concerns identified.
- If patients required specialist equipment to support them in their home, a request was made to an external equipment provider and equipment was delivered to the patient's home. Staff we spoke with did not identify any concerns regarding the availability of equipment.

Staff had access to the operational procedures for requesting equipment to be supplied to patients at home, these had been updated in April 2016. There was an emergency, out of hours service which enabled staff to request equipment at short notice.

Quality of records

- Patient records were held electronically, the majority of patient records were held on the same data base across the trust. This was the same record system used by some GPs and with patient consent records could be shared. The podiatry and musculoskeletal skeletal therapy teams used a different data base to record patient records.
- There was a trust wide risk identified relating to the accuracy and validity of information the trust provided from its patient information systems. Staff were reviewing electronic patient record data to highlight inaccuracies for example duplicate referrals, or where records had not been closed following a patient being discharged. In September 2016 the city west team had 1305 unfinished visits recorded on the electronic database. This was being addressed as part of the data review and included in the team's improvement and development plan.
- The quality and completeness of patient records was monitored by the trust. Patient records were reviewed as part of an internal clinical audit programme. We reviewed the findings of four record audits that had taken place across the service covering podiatry, continence clinics, speech and language therapy and the falls service. In the podiatry audit, reported in May 2016, 36 areas in the records were reviewed in 244 patient records. Nine areas were completely correct, 20 areas had improved from the previous audit. There had been a decline in the compliance of 16 areas including the completion of care plan documentation. An action

plan was in place to address areas of noncompliance, this included discussion at team meetings and a review of the electronic patient record to ensure ease of use by removing any duplication.

- We reviewed a sample of ninecare records. Plans of care and patients' progress were documented and updated. Records were stored securely and staff had access to them via a secure log in.
- Patient records were reviewed as part of the staff clinical supervision process. A random sample of notes were chosen and reviewed and this supported the learning process. In addition record audits had been completed.
- Paper records were held at the patient's home, and we saw these were updated following visits. Notes were removed from the patient's home when the visits were no longer required.
- Agency staff did not have access to the electronic patient records. (EPR) They were provided with a visit list taken from the EPR and completed a written record of each visit which was scanned onto the EPR by trust staff and any follow up visits were identified and scheduled.
- A review of patient records had been incorporated as part of the clinical supervision process for therapists. The quality of records was considered when reviewing the care delivered during the supervision process.
- The risk of nursing records, and care plans not being updated was being managed on the community health services directorate risk register. This acknowledged incomplete records posed a risk to patient safety.
- Record keeping and care planning was part of the trust's clinical mandatory training programme which staff were required to complete every two years.

Cleanliness, infection control and hygiene

- The trust had an infection prevention and control policy in place which outlined the responsibilities and roles of individual staff groups and the assurance processes relating to infection prevention and control across the trust. Training on infection prevention and control and hand hygiene was part of the trust's core mandatory training programme with a level one face to face training every three years and a yearly level two update accessed via the e learning system. In September 2016, data supplied by the trust showed 1081 staff (92%) out of a possible 1176 had completed their training across all area teams. Infection control link nurses were in place across the nursing and therapy teams.
- A trust wide internal infection prevention control audit reported in March 2016 highlighted insufficient bank staff had completed their infection prevention and control training. Data supplied by the trust for end of October 2016 showed 75.5% of bank staff working within the community health services directorate had attended hand hygiene training.
- We observed staff delivering care in clinics and in patients' homes. All staff were 'bare below the elbow' and demonstrated good hand hygiene. In a wound clinic we observed the aseptic non touch technique being used to dress lower leg wounds and appropriate personal protective equipment was worn by the staff. Non touch technique is the way a clinical procedure is carried out to prevent infection.
- In podiatry clinics we observed clean and dirty instruments being appropriately segregated and a documented procedure was in place for the handling and cleaning of used instruments.
- The clinic environments were visibly clean and we observed surfaces being cleaned between patients and waste being segregated prior to disposal. There was clear labelling in place on waste bins to enable the correct separation of waste. Sharps were disposed of in designated bins which were labelled with the first date of use and an accountable signature.

Mandatory training

- The trust's mandatory training policy set out the training requirements that were mandatory for staff to complete. The safe use of display screen equipment and safe use of medical devices training had been added to the mandatory training programme during 2016.
- Mandatory training was delivered by a combination of face to face training sessions and e learning, with modules accessible via the trust's intranet. A record of staff training was kept on the trust u learn data base.

Good

Are services safe?

- The trust target for mandatory training was 85% with the exception of information governance training which was 95%. The trust reporting period for courses which were attended annually was the previous 13 months.
- Following our previous inspection in March 2015 the trust were required to ensure all staff, including bank staff, had received appropriate support, training and professional development necessary to for them to carry out the duties. The bank staff mandatory training completion rates had been lower than for permanent staff. Training data supplied by the trust showed this had not taken place in all teams or for bank staff. We were not assured the trust had addressed this requirement.
- In September 2016, in community health services for adults, substantive staff had met the trust's mandatory training target (85%) in seven out of 14 mandatory courses. Course completion rates for substantive staff across all teams ranged from 77% of staff to 96% of staff.
- However, there were variations in attendance across the teams. Several teams had failed to meet the trust target in three or more courses. The courses with the lowest completion rates were fire safety and safeguarding children. In five of the six community nursing teams attendance on some mandatory training courses was below 70%.
- There was a centralised staffing team responsible for the mandatory training of bank staff. Data supplied by the trust for the end of October 2016 showed that 98 bank staff required mandatory training on 13 topics. Attendance on all these courses was below the trust target of 85%. The lowest completion rates were in fire safety (57.1%) and the Mental Capacity Act 2015. (66.3%). Using a RAG rating system none of the mandatory / statutory training compliance rates for this staff group were green, which is above the trust's own target.
- The musculoskeletal physiotherapy team, long term conditions team, speech and language therapists and county wide podiatry teams met the trust training target in all but one course.

Assessing and responding to patient risk

- Patients could access the Leicester, Leicestershire and Rutland community health services via a single point of access. This was a call centre and was available 24 hours every. Providing a single point of contact enabled a consistent approach to triage calls and respond to patients' needs. If a clinician had not already categorised a call, staff assessed the level of urgency against documented criteria. There were three levels of response; urgent within two hours, same day, and planned.
- Risk assessments were completed for each patient as part of the initial visit or appointment. Recognised assessment tools were used to inform care plans and treatment. Assessment tools included pressure area assessment and nutrition status assessment tools. Where patients' needs changed, these were identified on subsequent visits and changes made to the plan of care.
- We observed part of a board round carried out by the intensive community support team. Decisions regarding the discharge of patients from the team's care included discussion about patients' known risks for example their risk of falls and whether equipment that had been supplied had helped to reduce their risk and whether re assessments had been completed with the patient using the equipment. A board round was a virtual ward round where members of the team reviewed and discussed a patient's condition, treatment and plan of care.
- We observed a patient assessment being completed during a clinic appointment. Information was obtained regarding the patient's long term condition, current medication, symptoms and their concerns. A physical examination was then completed. All this information was used to determine what treatment was required, and the frequency of the treatment. This information was all recorded on the electronic patient record and was available to inform future assessments and to determine changes to the level of risk.
- In podiatry the electronic patient record included foot diagrams where patient assessments could be accurately recorded on the computer including the exact location of any areas of concern.
- We observed a nurse meeting; staff identified any known risks and updated the rest of the team, for example the need for additional medication to be prescribed and available for the next visit.

Good

Are services safe?

- We observed the assessment process completed by the coordinator of the night service. The coordinator assessed the referral information which had been received asking for a visit by the team, a phone call was made to the patient's home to establish more details or to provide advice. All this information was then used to determine what care or support the patient required and determined which staff would be asked to visit the patient.
- There had been an increase in the number of avoidable pressure areas in community health services during the first quarter of 2016. In July 2016 a reduction in avoidable pressure ulcer action plan was established by the city planned care team. This was part of a wider trust action plan to reduce the number of pressure ulcers.In June 2016, incidents were reviewed and common themes identified, nurses from across the teams had been involved in the development of the improvement plan. Required changes were identified, including patient allocation needs to facilitate continuity of care and registered nurses having accountability for named patients' plans of care. Teams were accessing on line training and additional support from the tissue viability nurse. The service provided data from July to September 2016, there had been a reduction in the number of category two pressure ulcers and no category three or four ulcers from July to September 2016. This was a good example of the service assessing and responding to risk.
- Referrals to the community therapy teams were triaged to assess them for the degree of urgency, this determined whether patients would be seen within 72 hours, 10 days or 20 days.

Staffing levels and caseload

- Insufficient numbers of substantive staff was a risk identified on the community health services risk register and this was having an impact on staff being able to deliver safe and consistent patient care.
- Data supplied by the trust for August 2016 showed a 3.4% vacancy rate for qualified nurses. This had increased from June 2016 when the qualified nurse vacancy rate had been 0.2%. The unqualified nurse vacancy rate had remained largely unchanged since June 2016 and was 40%.
- Vacancy rates and sickness rates varied across the community teams and across different services. We noted a high level of sickness across the city area teams. There were 179 substantive nursing staff employed and an average sickness rate across the five teams of 7.4%. However, the highest sickness levels (12.6%) were in the city unscheduled care team. The England average absence rates for July 2016 were 4.7% for qualified nursing staff and 6.2% for unqualified nursing staff.
- We spoke with managers from the city area teams, they explained there were 14.8 whole time equivalent (WTE) vacancies across the city teams and they had experienced high levels of staff sickness. In the city east team 1499 days had been lost to staff sickness in the previous 12 months.
- Bank and agency staff were used to cover shifts which were not filled by permanent staff.From June to August 2016 the number of shifts filled by bank staff was 687 and 1454 shifts were filled by agency staff.During the same period 279 shifts remained unfilled.
- There are no nationally accredited acuity and dependency tools to determine staffing levels for community nurse staffing taking into account patient acuity to inform safe caseload levels. Work had been carried out previously in the trust on length of visit times and caseload size and this data was used to inform the current allocation of visits. A manager gave us examples of approximate length of visits, a full holistic patient assessment was an hour, 30 to 40 minutes for a dressing and a shorter regular visit to administer insulin would be 20 minutes.
- We reviewed the trust's 'blue print' document, a handbook for community nursing and therapy teams which contained several examples of the types of visits and the anticipated length of time per visit. This was consistent with what the manager had explained. Productivity measures and key assumptions on how many visits were anticipated to be completed by each grade of staff per working day were set out. It was anticipated a qualified community nurse could complete between nine and 12 visits per day, with travel time per day of one hour 16 minutes. An unqualified nurse could complete 15 visits with the same travel

allowance. Documented protocols for managing service demand which exceeded staffing resources and the standard operating procedure for recruiting agency and bank staff was also included in the blue print.

- Some staff had large caseloads. We spoke with operational managers and community nurses about the numbers of visits staff scheduled for completion in a day. Staff and managers reported caseloads were challenging and visits numbers were consistently high. In two teams delivering planned care, staff explained they regularly had 18 visits to complete in a day. Another member of staff who we accompanied on visits had an average 12 visits per day. Managers were aware of the large caseloads, the increasing demand for services and the increasing dependency for patients requiring community care. In the city area a business case had been approved for five (WTE) additional staff.
- Managers could plan and balance district nurse staffing across trust areas. They had access to the staffing levels and caseloads across the entire area covered by the trust. This provided live data and identified where there were low staffing numbers, where teams had been unable to fill shifts and information on the number of scheduled visits. Managers explained staff were moved within their areas for example the city, east and west to cover teams that had staffing gaps.
- One manager explained earlier in 2016 staff had moved to support other areas. The city area had experienced particular staffing difficulties and staff from another area had covered some of the city clinics. This was only possible when an area did not have their own vacancies or absences to cover.
- Staff in the planned care teams explained the high visit numbers resulted in them finishing late the majority of the time, but this was the only way to ensure patient visits were completed and there was no impact on patient care. The blue print document set down the procedure for when visits could not be completed due to a shortage of time. This was to contact the patient to discuss whether the visit could be scheduled for the next day or whether a visit from the night service was required.City teams explained their workloads were consistently high with insufficient staff available to make visit numbers manageable. We were told this by several staff working in the city area and observed how staff appeared rushed when visiting patients.
- Staff explained the time spent travelling, either delayed in heavy city traffic or travelling to rural locations had a significant impact on the number of visits that could be carried out within their contracted hours. This also resulted in staff finishing late or starting early to complete the visits they were allocated.
- In December 2016 the allocation of work was due to change. Previously unscheduled care had all been dealt with by one team and planned care by another. There was an imminent change due which meant the planned teams were also going to be covering the unscheduled work where it did not fall within the intensive community support teams remit. Some staff were apprehensive whether the unscheduled work would make an already very busy planned schedule of visits even more difficult to complete.
- Working hours had recently changed and the planned teams were providing cover from 8am to 8pm by using a two shift system. This had been very recently introduced and we did not receive any negative feedback from staff about this change in the shift pattern which meant planned visits were taking place over a longer day.
- The team providing the night service where all work was unscheduled, had audited the amount of work coming into the team and had put a business case together for more staff. This team used bank but no agency staff and staff from within the team worked additional shifts to cover staff shortages. The service adopted a flexible approach to their workload where they staffed up to four virtual beds with a member of staff remaining in a patient's home overnight and visits throughout the night to provide care as required. Where staffing levels had the potential to impact on the team's ability to respond within their two hour response time, the team updated the area teams as early as possible in the day that response times may be longer than two hours.

Managing anticipated risks

- Risks had been identified within the community health services for adults service area and were managed via the community health services risk register. Current risks included the accuracy and validity of data on the trust's patient information system. A review of the data was being completed to highlight inaccuracies for example duplicate referrals, or where records had not been closed following a patient being discharged.

Good

Are services safe?

- Insufficient substantive staffing was recorded as a risk. Managers informed is in one area there had been approval for five additional staff to be employed. Low staffing numbers had led to the trust relying on agency staff to supplement their staffing resources. The use of agency staff was also recorded on the risk register. Staff within the community nursing teams explained the allocation of the visits took into account the skills of the staff on the rota including agency staff.
- There was a risk identified that care records were not being updated in line with patients' changing needs. In addition to scheduled record audits, a review of patient records had been incorporated into the clinical supervision process.
- Area teams were aware of the potential risk of being unable to deliver services due to adverse weather. There were volunteer drivers with suitably equipped vehicles to deal with adverse weather who would assist them to carry out essential visits for example to administer essential medication.
- We asked a manager about business continuity plans. They were able to describe the plan which covered a range of situations and provided specific actions to be delegated to staff depending on their level of seniority.

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:

- We saw effective multidisciplinary team working across and within teams. Care was patient focused and planned and delivered in line with current evidence and standards.
- Referrals into the service came via a single point of access which made the services easily accessible to patients and other health care professionals. There were systems in place to manage referrals and for work to be allocated in a timely manner.
- There was a planned programme of audits, which monitored outcomes and highlighted areas for improvement. Findings were shared and re audits conducted to monitor change. Therapy services routinely reviewed patients' outcomes using a patient self-assessment process.
- Staff had the skills and expertise to deliver the patient care that was required. Specialist nurses and advanced nurse practitioners provided additional specialist skills across all areas.
- Primary care coordinators, the night service and the intensive community support team all helped the patient's care pathway to be as smooth as possible.

However:

- Staff were struggling to access additional training to enhance their skills and develop their role due to their large caseloads.
- Some nursing teams still needed to formalise the process for clinical supervision. Completion figures were very low in some teams.

Evidence based care and treatment

- The trust held a clinical policy directory which included care bundles, protocols which were based on National Institute for Health and Care Excellence (NICE) guidance and best practice. The trust provided evidence of recent reviews that had taken place in the community health services to ensure policies and practice were in compliance with current recommended guidance.
- Trust policies were produced in line with NICE guidance which was used to support the delivery of care. As an example the trust's infection prevention and control policy was devised in line with NICE clinical guidance 139, on the prevention and control of healthcare-associated infections in primary and community care.
- In line with NICE clinical guidance 161, on the assessment and prevention of falls in older people, a specialist falls rehabilitation programme was provided by the community therapy teams in several local community locations.
- Patient assessments were carried out using templates that followed national guidelines. For example during the assessment of skin condition for the potential or actual risk from pressure damage and for assessing the nutritional status of a patient. The SSKIN care bundle was used. SSKIN is an acronym for surface, skin inspection, keep moving, incontinence and nutrition. This provides a framework and key areas to consider during the patient assessment process to prevent pressure area damage.
- The trust provided a pulmonary rehabilitation programme in line with NICE quality standards which set out treatment guidelines for people with stable chronic obstructive pulmonary disease (COPD) and exercise limitation due to breathlessness. Pulmonary rehabilitation is a programme of exercise and education for people with long-term lung conditions. The programme extended over 12 weeks with two sessions per week and consisted of patient education and exercise.
- We saw evidence that staff were kept up to date with the latest evidenced based practice which was applicable to

their area of care. In the city east hub and community services hub, the October 2016 performance report showed that a lower limb pathway of care had been implemented.

A pathway of care is a documented process that guides treatment, incorporating best practice guidelines and aids documenting a patient's progress and outcomes.

- We reviewed patient records of care provided by physiotherapists and saw evidence care had been received in line with national guidelines, patient's own goals were documented; discharge was well managed and encouraged patients to manage their own health.
- Staff confirmed they had access to trust policies on line and were able to demonstrate they could access these.

Pain relief

- Pain was well managed. We observed staff considering patients pain whilst providing care and treatment. Patients were asked to state if procedures were too uncomfortable. Actions were taken to minimise pain and discomfort, dressings were removed from wounds slowly and limbs were well supported during treatment. We reviewed a patient's wound care record this included a completed record following an assessment of their pain.
- During an exercise session patients discussed their use of pain relief at home to enable them to carry out certain activities and staff discussed ways in which exercises could be completed to minimise discomfort whilst still being beneficial.
- A patient self-assessment process was used by musculoskeletal physiotherapists to establish the impact and limitation pain was having on a person's ability to complete certain tasks. This enabled therapy to be planned to the patient's specific needs and with an understanding of how limiting their pain was.

Nutrition and hydration

- Staff assessed patients' risk of damage to or a deterioration in their pressure areas and assessed their nutritional status as part of their SSKIN assessment. This helped to establish if poor nutrition or inadequate fluid intake or obesity would impact on the condition or healing properties of a patient's skin.
- Community nurses were able to refer patients to the dietetic and nutrition services where they highlighted there was a need. The nutrition and dietetic service had specific referral criteria to ensure they would be able to provide assistance to the patients that were referred.
- Where patients were unable to take sufficient oral fluids and diet and enteral nutrition was prescribed this was managed by community by specialist dieticians as part of the home enteral nutrition service. Enteral feed is a complete feed administered directly into the stomach or small bowel via tubing. The specialist dieticians were responsible for the nutritional management of the patients. Community nurses supported families and patients where they were unable to change feeding equipment.
- Care plans included an appropriate nutrition and hydration assessment and management plan. A recognised nutritional assessment tool was used to assess patient's nutritional status and identify if patients were malnourished. We saw assessment documentation completed in patient records.
- Leaflets providing information on healthy eating were available in clinic areas.

Technology and telemedicine

- Assistive technology was used to support patients living at home. Medication devices had a built in alarm provided a reminder to patients to take their medication. These helped patients remain at home and promoted their independence.
- Community nurses used portable electronic devices to access the trust data base and patient electronic record system. Patient information was available to view when visiting a patient's home and nurses could update patient records at the time of the visit. This was then downloaded on the database on return to their base.
- Staff had been provided with smart phones to take photos of wounds. This enabled prompt advice to be obtained from the specialist tissue viability team. It also provided an accurate record of appearance of the wound which enabled progress or deterioration to be monitored.

Good

Are services effective?

- Staff had access to the trust data base from remote locations, for example when working from a location not owned by the trust staff could still access all the on line resources including policies and procedures and access their work emails. This enabled staff to work remotely.
- Therapists used digital equipment to measure the strength of patient's hand grip to monitor the effectiveness of therapy.
- There was tele-health monitoring of patients with chronic obstructive pulmonary disease (COPD) Tele-monitoring devices were used in patient's homes with severe COPD who had a high risk of hospital admissions; this helped patients self manage and monitor their condition. Patients put information about their condition in the electronic device. This was then reviewed by the respiratory nurses. This information was used to determine if additional health care advice or treatment was required.

Patient outcomes

- The trust had a planned clinical audit programme which incorporated new and re-audits. Audits were reported and findings published. The trust did not participate in the non mandatory national intermediate care audit. However, we were assured patient outcome information was monitored and used to inform improvements in the service.
- Therapy services used a modified version of recognised individual outcome measure tool to determine patient outcomes. The tool involved setting measurable goals which were patient focused and a self-evaluation to measure the outcome of the therapy. Patient goals were recorded on the electronic patient record which enabled their outcomes to be measured by any member of the therapy team.
- A retrospective case note audit was completed September 2016 to establish if outcome measures were being used consistently and providing reliable data on patient outcomes. A total of 483 patient records were audited. The audit highlighted new goals were not always set to reflect a patient's progression. Key actions were being devised in response to these findings which in the majority of areas had demonstrated consistent use of the tool.
- As part of the trust's 2015 / 2016 planned audit programme a re-audit had taken place on the compliance of care to NICE clinical guidance on the prevention of healthcare infections in primary care during the insertion and on-going care of urinary catheters. Data was collected via the observation of 46 patients. There was improvement in all aspects of observed care compared to theprevious audit and in the relevant staff training which had been completed. A re audit was planned for November 2016.
- From January to March 2016 there had been a re audit in the management of chronic heart failure to establish whether patients were being managed in line with NICE guidelines. Fourteen aspects of care were retrospectively audited in 88 patient records. Twelve areas showed improved compliance from the previous year's audit, one had stayed at 100% and three areas had declined slightly in compliance. Key actions and an action plan had been established, which included actions to improve the number of patients referred for review at the heart failure multidisciplinary meetings and a standardisation of documentation on the electric patient record.
- Data was collected to monitor the effectiveness of the primary care coordinators located at the acute trusts to help prevent unnecessary admissions into an acute hospital environment. The outcome of patients being referred to the service was monitored, including whether the team received appropriate referrals and the number of patients which were able to be discharged.
- Where patients were referred to the unscheduled care teams, including the night service the trust monitored how many calls were received requiring a two hour visit response time and how many patients received a visit within this timeframe.

Competent staff

- Some staff we spoke with had been supported to develop specific skills to enhance their role for example, specialist nurses and advanced nurse practitioners were non-medical prescribers.Some staff had received training on wound and leg ulcer care and could apply compression bandages and carry out doppler assessments. A doppler is a device used to assess the blood flow to a limb. Additional training had been

provided on the administration of medication via syringe drivers and to carry out ear syringing. During our observation of care being delivered staff were confident and knowledgeable about the care they provided.

- Staff including managers said access to additional training had become limited due to large caseloads and the shortage of staff.This had impacted on link nurses and designated champions for certain areas of care, as they were supporting the caseloads with little time to obtain further specialist knowledge.
- Specialist nurses had attended events and received training to ensure clinical practice remained up to date. One community nurse was completing additional clinical competency training to be able to perform ear syringing.
- Specialist nurses provided care to patients with longer term conditions who required on going management and care. These included respiratory and heart failure specialist nurses. Specialist nurses provided support to other health care professionals.
- Therapists were qualified and held accreditation in specialist areas for example hand therapy and delivered specialist care to patients across the trust.
- Staff had access to an online learning portal where training could be completed without the need to attend face to face training. All completed training was recorded on an on line data base. Staff explained they received email reminders when training was due to be completed.
- A therapy manager explained staff had four study leave days per year and training was available. Some specialist study days were provided by third parties and staff had access to them when they were hosted on trust premises. For new therapists starting their employment with the trust their induction included two days on a trust induction programme and then one day on a local site induction. Clinical induction was tailored to levels of experience with less experienced staff having three months of mentor support.
- Staff we spoke with explained they received support with their Nursing and Midwifery Council revalidation process. A training package had been developed and revalidation was recorded in the on line training data base. Revalidation champions had been identified in the trust. The senior nurse at the trust was the designated senior lead for nurse revalidation.
- Clinical supervision is a formal process for professionals to reflect on clinical practice. The trust had a clinical supervision policy which required a minimum of a one hour supervision session per quarter, staff confirmed it was usually carried out once every six weeks. The trust target for clinical supervision was 85%.
- From August 2015 to July 2016, 56.7% of adult community services had completed clinical supervision. There were very variable completion rates across the different teams, five teams of staff met or exceeded the trust target, a further seven teams achieved a completion rate 75% or above and the other 22 teams ranged from 11% to 74%. The trust were aware of the low levels of supervision recorded and believed the process took place but was not always accurately recorded.
- We saw the documentation used by a physiotherapist supervisor to record clinical supervisions. We spoke to supervisors and supervisees who confirmed the process was formal and documented, records were saved and the process was recorded on the training data base.
- An occupational therapist explained clinical supervision was once every six weeks but more frequently for new staff. Staff had an in service training session scheduled weekly into their calendars which was an opportunity to share learning and reflect in a group environment.
- As part of the process of reflection on professional practicein a one to one supervision five patient records were reviewed to support the reflective process, this also provided an opportunity to consider consistency, accuracy and completeness of patient records.
- A senior manager explained the nurse clinical supervision process was being changed to become more formalised in line with the current therapist clinical supervision process. One nurse confirmed supervision was performed in a group and this was due to change to an individual one to one supervision.
- The Trust did not provide a target for appraisal rates. Appraisal data provided by the trust for 1191 staff showed 85% (1012) had received an appraisal within the

previous 13 months. There were three community nursing teams where less than 75% of staff had received an appraisal, these teams were not all in one locality and were from both scheduled and unscheduled care.

Appraisals ensured staff had the opportunity to discuss their development needs or any support they may need in their role.

- Poor staff performance was managed. In the previous 12 months four members of staff had their contracts of employment terminated following a review of their conduct.

Multi-disciplinary working and coordinated care pathways

- We observed multidisciplinary working during board meetings and discussions between team members. Patient records were used by all members of the multidisciplinary team, this ensured care was coordinated. A board round was a virtual ward round where members of the team reviewed and discussed a patient's condition, treatment and plan of care.
- The intensive community support (ISC) team consisted of nurses, occupational therapists and physiotherapists working together to provide intensive support to patients in their own home. We observed a review of a patient's future care and potential discharge from an ICS team. This included information from a recent home therapy assessment as well as nurses discussing the patient's physical health.
- The intensive community support team (ICS) worked closely with social care services to ensure patients had been assessed and appropriate packages of care where in place before patients were discharged from the team's care. There had been a recent six week pilot of joint working between the ICS team and the local authority's home care assessment enablement team (HART).A HART team had been co located with an intensive community support team. Initial feedback had been positive and had seen benefits for patients. It was too soon after the pilot for any future work to be planned.
- In Rutland we spoke with the integration lead for Rutland's integrated health and social care service. This was a new, coordinated approach to health and social care, with services working together from the local authority, local health trusts and the voluntary sector, focused on supporting patients to be healthy and independent and provide support where necessary for them to remain in their own home.
- Primary care coordinators employed by the trust were based at the local acute hospitals and worked within several departments including the emergency department and acute frailty unit. They assessed patients following their initial admission to the emergency department to identify patients whose care could be safely provided by the community trust. The main aim being to avoid unnecessary admission to an acute hospital environment. Alternative places of care were the community hospital inpatient wards or at home with a safe level of support provided by the community nursing service.
- Some community nursing teams were co-located in GP surgeries and clinics were also held at health centres and GP surgeries throughout the city and counties. Some GPs used the same electronic record system as used by the community nursing teams. Where a patient gave their consent this made sharing of health records very timely.
- Multidisciplinary meetings were held and attended by staff from all professions. We observed an intensive community support team meeting, where nurses, occupational therapists, an advanced nurse practitioner and physiotherapists were all present. Specialist nurses explained they attended monthly MDT meetings with local GPs and had close working relationships with the consultants from acute trusts.
- Community matron posts had been recently established in the trust. One community matron felt collaborative working with GPs was improving. Advice and patient care was available from several specialists including the nutrition and dietetics service, speech and language therapists and from tissue visibility nursing services.
- A new community integrated neurology and stroke rehabilitation service had just been established at the trust. This integrated care model brought together members of the multidisciplinary team including nurses, dieticians, therapists and nurses with mental health expertise to provide a holistic approach to patient care.

Good

Are services effective?

Referral, transfer, discharge and transition

- The trust's single point of access (SPA) was available 24 hours a day 365 days a year. This ensured referrals were dealt with promptly. The service had a designated telephone number for health care professionals and there was access via fax and email. Referrals were received by the SPA and then forwarded to the correct service. Patients had a separate phone number to contact the service.
- Urgent requests were immediately allocated to the team in the correct geographical area and responded to within the appropriate timescale. Staff were notified of new referrals via the on line records system, where there was an urgent care need the nurses were contacted directly by telephone.
- Referrals for community health services were received from a wide variety of referrers, including GPs, patients and relatives, social care services and acute trusts.
- Patients discharged from hospital were often discharged into a virtual bed managed by one of the intensive community support teams. Staff from the team followed up the receipt of the initial referral with a phone call to the team discharging the patient, this ensured they had all the information they needed. We accompanied a nurse on a visit to a care home where hospital discharge paperwork was incomplete, however, the nurse ensured this did not impact on the patient's care.
- Following up to 10 days of intensive therapy and nursing support patients were discharged from the ICS team care and may be cared for by the planned care team if they needed on going nursing care. Some patients who hadn't become sufficiently independent following their discharge from hospital were supported with a package of social care. Ensuring this was in place before discharge enabled a smoother discharge process. When there was a delay getting a package of care a patient remained under the community nursing teams care until it was in place.
- Access to outpatient services for example podiatry, physiotherapy, dietician services or continence care was also by a referral process. Staff could directly refer patients to specialist services and patients could refer themselves to some for example podiatry. There was a fast access podiatry clinic available somewhere in the county every day Monday to Friday. This was a drop in service where no appointment was necessary and was for emergency foot care.
- Referral for the night service was also received via the SPA. On receipt of the referral the information was triaged by the coordinator of the team and a call made directly to the patient. The service provided a night service where a nurse would remain in the home all night. This was available for three nights and then any on-going care needs would be assessed by the community nursing teams. Patients could be re referred to the night service if they still required support in the night as a short term measure.

Access to information

- Staff had access to trust policies via the intranet, this included the trust's 2014 handbook for community nursing and therapy teams, known as the blue print. This provided information on the structure of the services, patient pathways, including referral protocols and response times. We saw a copy of this document was available to staff in one of the team base locations.
- Patient information stored electronically was available to staff via computer terminals in base locations and via mobile devices. We observed staff accessing patient electronic records and updating them following visits, access was password protected.
- Administration staff had access to the patient data base which included a communication tool where staff could be tasked with new pieces of work and messages could be passed on. One member of staff explained new tasks would not be accessible to staff out on visits, any urgent information would be telephoned through to the nurses.
- Agency staff were provided with a printed list of the visits they needed to complete during the day, they did not have access to the electronic patient record system therefore they did not have access to the same amount information as trust employees. Paper copies of patient records containing less detail about the patients, were left in the patient's home and could be accessed by the agency staff.

Good

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- starting their treatment. We did not witness any occasions where there was any reason to believe a patient did not have capacity to consent to their own treatment.
- The trust's consent to examination or treatment policy sets out what is and isn't consent and actions that were required where a patient may lack capacity to give consent. Staff training on consent was part of their record keeping training which was updated every two years. Staff were aware of the mental capacity assessment process, however, we did not see this applied in practice.
- Patient's consent was sought to share their health records with other parties for example their GP and this was documented on their record.
- Staff had attended training on the Mental Capacity Act 2005 which was part of the trust's mandatory training programme and across the service 76.8% of staff had completed the course. Completion rates varied across teams and areas with completion rate across 16 teams ranging from 55% to 100%, with 11 of the 16 teams achieving 75% and above.
- The trust reported a new e learning module had been made available to staff following a review of the Mental Capacity Act and Deprivation of Liberty Safeguards training.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Patients who provided feedback on the community nursing and therapy services via the NHS friends and family test were consistently positive about the service they had received
- Patients and their relatives were included in the planning and delivery of care. Staff listened to patients and encouraged them to be involved in their care.
- We observed staff delivering care; it was delivered with kindness and compassion. Patients' privacy and dignity was respected and staff were professional but approachable.
- Patients told us they were happy with the care they received, patients had felt the benefit of therapy and we observed the care being delivered with kindness and understanding.

Compassionate care

- Staff were observed delivering care in a variety of settings, including patients' own homes, in clinics and in group therapy sessions. All staff were observed to deliver care in a caring manner. Staff spoke kindly and with concern, helping to put patients at ease.
- Staff were professional in their approach and demonstrated confidence in the way they delivered the care. The majority of staff were calm and unhurried with staff taking the time to listen to patient's concerns. On one visit after the care had been delivered the patient was specifically asked if they or their relative wanted to ask any questions or if anything was worrying them. Patients in clinic appointments were given the time to talk about any related health issue which concerned them.
- Patient dignity was maintained by the way services were delivered. Doors were closed and clinic curtains drawn, staff knocked before entering clinic rooms and waited to be invited in. District nurses we observed asked patients whether it was alright to draw curtains in patient's homes to ensure examinations were carried out in private.
- We observed a group physiotherapy exercise class, the atmosphere was calm and relaxed, staff offered advice and encouragement, patients were engaged and motivated to take part.
- Patients attending a pulmonary rehabilitation session spoke of the service being welcoming, had motivated them to do more exercise, and provided an individual exercise programme where they could progress at their own pace.
- During clinic appointments patients with limited mobility were shown understanding and patience when they entered and left clinic rooms. Assistance was offered whilst respecting the patient's wishes to be independent.
- Staff were gentle when delivering care that could be uncomfortable for patients, taking time to remove dressings slowly and keeping them informed of what to expect.
- We observed a nurse prioritising a patient's needs, during a visit to a care home. Hospital discharge paperwork was incomplete and the nurse used her experience to be able to deliver safe care and provided support to the care home staff.
- The trust participated in the NHS Friends and Family test to obtain feedback from patients. The test is a single question survey which asks patients whether they would recommend the NHS service they had received to friends and family who may need similar treatment or care. Feedback was obtained from patients who had received community services including nursing and therapy.

  From April 2016 to September 2016, between 94% and 100% of patients recommended the community nursing service they had received, 97% to 100% of patients recommended the community therapy services they had received.

Good

Are services caring?

Understanding and involvement of patients and those close to them

- We observed patients and their relatives being involved in their care. Time was taken to listen to patient's concerns and then care was planned and delivered.
- With the patient's consent families were welcomed into clinic rooms whilst care was delivered. This enabled them to be informed and involved in the patient's care and to provide support for the patient.
- When further appointments were being booked we observed staff had a good understanding of patient's and relative's personal commitments and we saw appointments made on specific days or times to accommodate these.
- In a wound clinic we saw patients being involved in their care by applying cream to their skin that was made accessible during a dressing change. We also observed patient preferences were sought on the type of outer bandaging that was applied.
- During home visits we saw relatives being involved in the assessment process of what progress they had seen made, staff recognised relatives were able to provide valuable information about the any progress that had been made or concerns they had since the previous visit.
- Staff were observed to take time to speak to patients and their relatives in a way they would understand. The terminology that was used was understandable and checks were made to make sure patients and their relatives understood their care. Information leaflets were available for patients who required them.
- In therapy services patients were involved in setting their own treatment goals and their therapy was planned in line with their wishes. This made goals personal and patients had a good understanding of what they were hoping to achieve. Patients explained they had started to see improvements after being on a pulmonary exercise programme.

Emotional support

- We observed a member of staff on a home visit where a patient's mobility had recently been reduced. The patient and their relative were both offered reassurance to help reduce their anxieties over the potential impact the patient's reduced mobility could have. The advice they received focused on the positive steps the patient had made since their discharge from hospital and gave encouragement to remain positive and to help them progress even further.
- Staff showed concern for patients and relatives general well-being not just their physical health. Staff demonstrated their understanding of the impact of a sudden deterioration in physical health could have on a patient's emotional well-being.
- Some patients had been attending for treatment over several months and progress had been slow, others required on going care due to long term conditions that would always require treatment. Staff recognised the impact on patients of prolonged treatment.
- We observed telephone conversations with patients and their relatives, staff were calming in their approach to situations that could have caused anxieties for patients and their families. Reassurance was given that help was going to be provided and conversations were not ended until staff were assured they had sufficiently reassured the patient that help was available and they understood what was going to happen.
- We saw how staff understood what was important to patients' well-being. They appreciated what mattered to patients; we saw where a hand splint had been custom made and ensured a patient could still carry out her craft activities. The patient had made a gift to say thank you.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated responsive as requires improvement because:

- Patients seeking non-urgent treatment sometimes had to wait for a long time. From May to October 2016 the unscheduled nursing service only met its two hour visit target in 53% of cases.Waiting list times for musculoskeletal physiotherapy could be longer than 20 weeks and the wait for continence treatment could be over 40 weeks.
- There was no structured approach to equality and diversity, or addressing unmet need. We did see therapists and nurses respect cultural differences and tailor services to individual needs.
- Capacity was not planned to meet local demand in a systematic way. However, local areas were developing approaches to better manage this, considering skill sets and lengths of different types of calls.

However :

- Adult community health services worked well in partnership with other organisations to provide choice and locally based services for patients. This helped patients avoid going into hospital if they wished to remain at home.
- Services adapted provision to a variety of cultural needs and could support patients with interpreting services either face to face or on the telephone where necessary. Therapists and nurses also tailored service to individual needs, for example, designing hand supports so patients could continue with their day to day activities.
- Patients and carers could access services by telephone 24 hours a day through the shared single point of access. The services prioritised urgent need and high priority heart failure, musculoskeletal, respiratory and podiatry patients were seen within agreed timescales. The trust learned from formal complaints and had improved the complaints process for customers.

Planning and delivering services which meet people's needs

- Commissioners, other providers and relevant stakeholders were involved in planning services. The services contributed to the local Better Care Together partnership aiming to deliver integrated health and social care. Better Care Together is the five-year programme of work to transform the health and social care system in Leicester, Leicestershire and Rutland by 2019 by empowering people to have control over their own health and wellbeing, and provide timely care closer to home.
- The projects arising from this partnership programme led to projects which benefitted local people, for example, in Rutland this led to an integrated hospital and re-ablement service. This included better planning ahead for what was needed for the patient's discharge, such as care packages and adaptations. As a result, these were in place on the day the patient returned home, making a smooth transition more likely.
- Adult community health services worked in partnership with local adult social services to offer patient choice. Intensive community support teams provided intensive care and support seven days a week, for a period of up to 10 days. This gave patients the choice of staying in their home rather than going into hospital or a care home.
- Adult community health services worked with other health providers to avoid hospital admissions. Patients could be referred via the jointly run single point of access to services within the community.

  A night service provided staff for up to four patients to have a nurse all night in a patient's home as well as do visits across Leicester, Leicestershire and Rutland to deliver care and to help keep them safe.
- Services used information about peaks in demand to plan staffing. They changed shift arrangements to ensure that daytime unscheduled visit staff worked until 10 pm and unscheduled visit night-time staff started work at 8 pm. This provided a short term boost in staffing to meet the evening peak in demand because there was an overlap between day and night staff between 8pm and 10 pm.

Requires improvement

Are services responsive to people's needs?

- Services provided flexibility, choice and where possible, continuity of care. Community nurses told us they tried to offer patients continuity because it was reassuring for many chronically ill patients to see a familiar face. We heard from night teams about how they sent the same health care assistant or nurse to sit with patients at home.However, nurses had to cover for each other's absence during sickness and holidays so this could not be guaranteed. In the East area, leaders tried to rebalance caseloads which led to lack of continuity for some patients.
- Services were geographically planned to meet the needs of local people. The service had been restructured into local hubs so patients would become familiar with a small group of nurses and care assistants. The service ensured they visited patients at home alone early in the evening and visited care homes afterwards, depending on clinical need. We saw local clinics which offered specialist services. The respiratory care nurse and community long term conditions team provided outpatient asthma and clinic services to the local population at Wigston. Local GPs referred patients within the same health centre to ensure a joined up service was delivered at a local level. The service had specialist clinic nurses who gave patients local access to treatment. We saw a musculoskeletal nurse led clinic at Market Harborough and 60 – 70% of referrals to this clinic (50% hospital, 50% GP) would have needed an orthopaedic consultant otherwise.
- The services sometimes used informal information about the needs of local people to plan services. For example, the night district nurse team realised there was a growing need in the community for intravenous treatments and for patients approaching the end of their life to receive treatment via syringe pumps. They ensured that some members of their team were trained to meet this need.
- Although services identified unmet needs they could not always adjust quickly to address them. For example, community nurses in rural areas told us about an increase in demand for end of life services. The nurses had to cover each other's shifts in the case of sickness or holiday absence and did not have time to go to specific end of life training. The end of life nurse champion also covered for colleague's shifts, and did not have time to train staff.

Equality and diversity

- Services were informally rather than formally planned to take account of the needs of different people. The 'blueprint,' or adult community services handbook, did not make equality and diversity in patient treatment explicit, or specify differentiate patient approaches. Instead it stated that staff, rather than patients should be treated with no discrimination. This meant that action on equality and diversity was not coordinated or measured.
- Staff were trained on equality and diversity. In October 2016 100% of most staff groups had completed equality and diversity training, as part of their mandatory training and 94% and 98% of podiatrists and speech and language therapists respectively.
- Services had access to translation and interpreting services. The trust had an interpreting service which included face to face, telephone and sign language interpreting. The trust had a manual, with useful procedures and expressions, explaining how to use language services. The musculoskeletal physiotherapy service used interpreters in patient assessments for new and follow up patients which added to the appointment time. This caused delays in the waiting time and the service. Staff told us assessment time for new appointments was 45 minutes and 30 minutes for follow ups.
- We observed staff assessing a patient at Braunstone whose first language was not English. Staff were respectful of the patient's ethnic origin, frequently asking their permission for any physical contact which was necessary for the examination. They ensured understanding and used very clear English.
- The services had arrangements to meet the diverse needs of people, for example staff in rural areas of the county were aware of the risk of rural isolation and used contacts in specific care agencies to ensure that patients were supported. Nurses took care to tailor treatment to patients' lifestyles, for example ensuring that patients could comfortably put shoes on over foot bandages or creating an orthopaedic hand support for a patient who wished to continue to crochet.Some physiotherapists also offered acupuncture, which increased patient choice.

Requires improvement

Are services responsive to people's needs?

- The pulmonary rehabilitation service took into account the needs of the patient group. They organised patient transport to take patients to hospital and all venues were wheelchair or walking aid accessible. If patients could not attend a session due to illness, they could re-start at any point
- Services worked with partner organisations to provide relevant patient services in less advantaged areas. For example, there was an exercise class in the health centre, and a range of exercise activities run by the local authority at Braunstone, tailored to people's needs. Course leaders set personal goals at the start of treatment and modified exercises so they could be done at home, for example using a cushion instead of a trampoline.

Meeting the needs of people in vulnerable circumstances

- Services were not always planned, delivered and coordinated to take into account people with complex needs. Not all nurses had training on dementia, or learning disabilities. Not all nurses had completed training on adult safeguarding, although in many cases, managers had planned their training before the end of the financial year.There were no nurse champions for patients living with dementia.

Access to the right care at the right time

- Patients did not always have timely access to routine appointments. Staff told us there were long maximum waiting list times for certain services which had a four week target. These included routine musculoskeletal physiotherapy (20 weeks for chronic back pain but could be up to 26 weeks) at two out of eight sites, the continence clinic (up to 46 weeks) and 18 weeks for respiratory clinics.Physiotherapists told us that demand exceeded capacity for routine patient appointments.
- Patients did not always have access to community nurse care within the expected timescale. Unscheduled (reactive) community nursing services had a target to attend these calls within two hours. In August, September and October 2016 they attended 58%, 55% and 55% respectively of calls within two hours, so many patients waited longer than two hours.
- The night service was part of the unscheduled care, on receipt of a referral they had two hour visit target. Data supplied by the trust showed from November 2015 to October 2016 the night service achieved the two hour target 67% to 81% of the time. The team achieved a three hour response 80% to 91% of the time.
- Sometimes community nurses missed appointments. Staff told us when this happened, they rang the patient to explain and to re-schedule the appointment. We requested details about how many appointments were missed and rescheduled but the trust did not provide this. If there was a staff shortage, the night service warned local area hubs and prioritised calls in order of clinical need.
- The community therapy team did not meet agreed waiting time targets. They did not achieve the 3 day, 10 day or 20 day targets in September 2016, underperforming at a similar level to the previous month. In September they saw 73%, 42% and 66% of patients respectively within the 3, 10, and 20 working days targets. This meant non-urgent patients could wait longer than the agreed standard. The board report showed this could be up to 33 weeks.
- In musculoskeletal physiotherapy in Leicester City in May, June and July 2016, patient DNA (did not attend) rates were 11%, 11% and 12.5% respectively. In a high demand service, this was inefficient and the service responded by learning from other services within the trust and implementing letter and text reminders. The DNA rate had slightly improved when we inspected.
- The service prioritised care and treatment for people with the most urgent needs. For example, 93% of urgent musculoskeletal physiotherapy patients waited less than the urgent target time of 5 days, 100% of podiatry patients and 100% of end of life heart failure patients were seen within two weeks in September 2016. Routine and urgent speech therapy waiting times were meeting target level.
- The service was achieving its key aim of avoiding unnecessary admissions to hospital for patients.Primary care coordinators achieved 138, 129 and 176 accident and emergency deflections in May 2016 (avoiding A&E treatment for patients).
- Clinic appointments were generally on time. We asked patients at various clinics during our inspection and six

said they were generally on time, two said clinics were occasionally less than 15 minutes late. We observed staff in wound clinics and podiatry clinics making sure they were keeping to appointment times.

- Specialist nurses ran heart failure clinics which prioritised care for patients with the most urgent needs. The service had a temporary waiting list in place because it was failing to meet its four week target but gave priority to patients who had been discharged home from hospital following a positive cardiac diagnosis. The specialist nurse would see patients at home if they were too ill to attend the clinic. There was a triage system in place to ensure effective and appropriate referrals.
- Nurses used technology to ensure that patients received timely care for pressure ulcers. They used their computers and smart phones and could take photos of ulcers to make a referral to the tissue viability nurse. This meant the tissue viability nurse could advise more quickly on managing the pressure ulcer, and prevent it becoming more serious.
- Patients could access services by telephone 24 hours a day, seven days a week. The services had a call centre called the single point of access which also took out of hours calls, working with the night service. In July 2016, the single point of access call centre had a low call abandonment rate (calls not getting through) of 2%, which meant that the majority of calls were answered.
- Some of the underperforming services were showing a very recent trend of improvement. In September 2016, the service saw 32% of routine musculoskeletal physiotherapy patients within four weeks which was a slight improvement on 23% the previous month.

Learning from complaints and concerns

- Patients told us they would know how to make a complaint or raise concerns. Some of them said they would ask the receptionist or nurse how to do this. We saw posters in clinics which explained how to complain, but we did not see any leaflets explaining the procedure to patients treated in their own homes.
- The trust was strengthening the system for processing complaints. The complaints team introduced a complaint management document which allowed the complaint to be categorised correctly, making the identification of themes and trends easier.The trust handled complaints effectively and confidentially. They kept formal records and informed the complainant about progress.
- Adult community health services learned from complaints and identified themes. For example, recurring complaint themes for July 2016 were quality of care, delayed or missed community nurse visits and rudeness or the attitude of community nurses. The trust changed leadership and organisational arrangements in community nursing to address these issues.Community service operational managers worked with the single point of access (SPA) call centre to ensure call handlers were able to forward callers to the community nursing team in an effort to resolve issues locally. Following a complaint about a community hospital, managers identified gaps in staff knowledge of the continuing health care (CHC) process, and developed a training plan to address this.
- Therapists learned from complaints. We heard from podiatrists how a complaint from a diabetic patient led the service to develop a procedure to ensure that both of the patient's feet were checked. This was supported by computer system changes so that podiatrists could not complete the record without checking both feet.
- Adult community services received 21% of the trust complaints between August 2015 and July 2016. The most complaints upheld after investigation were at Braunstone, Leicester District Nursing (4); Hinckley and Bosworth District Nursing (3); Lyn House, Oadby and Wigston District Nursing(4) and Merlyn Vaz, Leicester City District Nursing (4).
- Staff were made aware of complaints and actions taken to improve services. Managers discussed complaints at hub (local area) meetings and cascaded the knowledge down.

Requires improvement

Are services well-led?

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

Summary

We rated well-led as requires improvement because:

- Whilst the services had a strategy which pulled together actions and measures to work towards divisional or partnership objectives, and service plans staff and managers we spoke with were not aware of the plans or how their roles supported the strategy. Performance reporting arrangements at service level were still in development.
- Performance and risk management arrangements were not robust enough to ensure leaders always took timely action. High caseloads persisted in some areas and had a detrimental effect on staff morale,development and retention.
- Data quality was not reliable, and services did not measure key indicators which would help deliver a patient focused service, for example, monitoring missed or delayed district nurse visits.
- The services did not systematically learn from external sources. They lacked information on best practice in other organisations so could not learn from this. Following the CQC inspection in 2015, the service was slow to act on areas for improvement.

However:

- There was a system of governance meetings to ensure that leaders discussed complaints, quality and incidents.Team meetings enabled problem solving at service level and helped staff share information with colleagues about incidents and quality improvement.
- Services had systems to gather patient and staff feedback, although these were not always effectively translated into service improvements.
- The services had a focus on helping people to remain in their own homes. Staff understood this and the trust's values.

Service vision and strategy

- The services did not have a robust realistic strategy or directorate plan which integrated planning on partnership priorities outlined in the Better Care Together with trust wide objectives such as quality objectives detailed in the quality strategy. The services did not have action plans with target setting, service plans or programme or project plans to ensure that the vision became reality. Therefore services did not systematically monitor progress against the partnership or quality initiatives at service level.
- Although the medium to long term strategy was not clear, the services had operational guidance. The directorate detailed standard operational procedures in a handbook called the 'community health services blueprint' which specified 'the way we do things around here'.This included a cultural charter, key changes to the patient journey, and process flows explaining how to do things.
- The blueprint handbook was based on national voices feedback. National voices is a grouping of 130 health and social care charities commissioned by NHS England to help define what integrated care means for people. Staff developed 'staff voices statements' which set out what is needed to be able to respond to patients' and carer's expectations. They also defined an ideal culture in order to deliver the vision, which was outlined in the cultural charter in the blueprint. This involvement enabled staff to influence and own the principles in the blueprint.
- Staff understood the trust's values of respect, integrity, compassion and trust. They understood their care giving role in adult community health services but did not know about future plans.

Governance, risk management and quality measurement

- Adult community health services, in this case community nursing and therapies such as occupational therapy, podiatry, physiotherapy and continence clinics, formed part of the community health services

directorate. This was led by a director. There was a head of service and a clinical director for the community based services.The division had restructured into hubs which combined therapists with community nurses. Staff told us this resulted in closer working between the services.

- The performance and quality reporting arrangements for community services at local hub level were still in development when we inspected. Team leaders for community nursing and therapy submitted performance and quality reports of varying styles and content to their line managers. Hub (local area) teams had staff meetings to review quality issues in line with the trust's self-regulation approach, but this did not always include the review of complaint and incidents
- The services risk management and performance management arrangements were not effective enough to ensure managers solved key service problems in a timely way. In community nursing, high caseloads were a recognised risk. Despite this, the problem persisted in some teams and this had an adverse effect on staff retention, sickness and morale. Some new nurses were recruited to the city team, but other teams were also stretched. Whilst the service had carried out an analysis of turnover and what they could do to retain staff, the problem was unresolved.
- The assurance system did not provide managers with the right information to ensure that patients' needs were met. There was no system for identifying delayed or missed community nurses visits.
- Data quality was not reliable. The trust's leadership team were aware of this and had a data quality improvement plan. Staff told us about a clean-up of referral data; some of the referrals were duplicates. Patient details were not always linked to the correct referral or patients had been seen but the data had been inputted incorrectly. Staff told us about plans to compile and monitor reliable patient tracking lists, however, we did not see any evidence that this had been completed or evaluated at the time of our inspection.
- Performance was not managed locally. Trust level performance staff requested data from individual services to compile performance reports for the board and commissioners. They passed information back to the services asking for answers to underperformance issues. Services did not own and monitor their own performance data or rectify issues at the earliest opportunity.
- Divisional/departmental governance arrangements were not clear and accessible to dispersed teams. We spoke with community nurses and therapists who felt part of their immediate team but who could not tell us about divisional management arrangements.
- Adult community health services had not fully implemented the trust's self-regulation approach. This was a self-assessment tool designed to identify improvements, using the Care Quality Commission framework of safe, effective, caring, responsive and well led.In the second quarter of 2016/2017 the trust introduced this approach to various inpatient community services such as: wards for older people with mental health problems, community services for older people and end of life care. However, self-regulation was either very new or not in place in adult community health services and they had not benefitted from the resulting self-analysis or continuous improvement.Services were starting to be more self-aware and suggesting areas of potential improvement such as caseload reviews, service planning and better record keeping.
- Quarterly performance review meetings between adult community health services and the trust-wide senior management group ensured an exchange of information at senior level.Within the division, an assurance and quality group reviewed performance and quality reports from local hubs but also from problem solving groups such as the serious incidents group, clinical effectiveness group and patient safety and experience group. The patient safety and experience group took reports from the pressures ulcer group and the patient experience group
- Front line staff were clear about their roles and what they were accountable for.

Leadership of this service

- Leadership was variable. Some leaders were new in post and were still acquiring the skills they needed to carry out their roles effectively, for example, project management or knowledge of a specialist area. They

were also getting to know teams. Some leaders had useful ideas they gained from elsewhere in the division or from leadership training and were starting to implement these, for example, action plans to increase clinical supervision, new meeting formats or shift arrangements. However, some team members told us too much structural change could be unsettling.

- Leaders understood the challenges to good quality care but had not fully addressed them. For example, city team leaders identified staffing as a key element of delivering good and timely district nursing care, and put together a business case for five more qualified nurses. They had a good response to this and hoped that new nurses would start work early in 2017.However, leaders were also concerned about retaining existing nurse staff, but had not put a plan in place for this.
- Teams felt connected to their local hub but not always to the rest of the division. They felt their local leaders were visible, helpful and approachable. Most teams we asked told us they would recognise a member of the senior management team even if they had not seen them recently. Some local leaders were new in post and getting used to their roles.We heard from staff that this could be unsettling.
- The trust was starting to invest in leadership. We heard from local leaders across the county that some of them had receiving trust funded leadership training. The trust launched the 'WeNurture' talent management programme in August 2016, with 29 staff taking part in the initiative.

Culture within this service

- Culture in the services depended on type of service, quality of leadership and geographical location. Community nurse morale was not always good. Nursing staff told us they felt respected but sometimes felt stressed and overworked by the need to cover for colleagues who were on leave or off sick. They told us this affected morale and sometimes staff became run down and ill. In the Leicester city area, some staff had to make 18 visits a day due to sickness and other absence.
- Some services had high sickness rates. Unscheduled care, city locality had the highest percentage of sickness of a team over the size of 10 members with 12.6% of permanent staff off sick. This was closely followed by west planned care at Hinckley hub with 11.4% staff off sick.
- Some therapy services encouraged retention. The musculoskeletal physiotherapy service encouraged staff to move into different roles within their pay grade and offered transfers to community inpatients services within the trust, to enable the team to compete with the skill set in a large hospital
- Occupational therapy teams told us they had good operational leadership and a collaborative leadership team. Staff were resilient and coping with change. Podiatry staff described their culture as open and friendly, responsive to complaints and with a good team leader. They felt their caseload was manageable.
- Staff development was limited by caseload pressures. Staff told us it was difficult to do anything more than mandatory training because of time pressures. We heard that performance issues were addressed at all levels. We observed team meetings where staff and leaders worked collaboratively and shared responsibility to deliver good quality care.
- The services had a focus on helping people to continue in their own homes. We observed community nurses and therapists encouraging self-care.Nurses at clinics explained how patients could apply dressings and bandages between appointments and podiatrists showed patients how they could take care of their own feet and gave patients an informative leaflet to refer to.Avoiding hospital admission was a key aim of the service and it demonstrated it met these aims through various projects, for example, through the use of primary care coordinators.
- The service took measures to protect staff who worked alone. In remote rural areas, for example, lone working staff had a special number they could ring if they were concerned. In this case, the police would attend in ten minutes. Staff carried torches, had a 'text buddy' to check on their safety and there was a record of all staff car registrations. Staff were trained on handling conflict (disengagement training) and knew how to react if personal risk suddenly increased. After a night staff member was approached in the locality of a call, staff all received extra health and safety training. The trust had a

lone worker policy produced in January 2015. This included carrying out risk assessments on lone visits where patients were known to be unpredictable or own a vicious dog. This meant the risk of lone working was minimised.

Public engagement

- The trust was developing communication with the public.A listening into action (LiA) patient involvement event was held in October 2016 and the findings would inform the way forward with identified work streams. An "LIA pass it on" event was held in September 2016. This included how to support staff to involve service users and carers and develop a central point for patient involvement resources.
- Patient feedback enabled the service to better communicate about services. The patient advice and liaison service fed back some concerns about podiatry to community health services. For example, some podiatry service users were unhappy about not being eligible for a home visit. The team explained the criteria to service users, to avoid future misunderstandings.
- Patient feedback in musculoskeletal physiotherapy increased after they introduced an app to leave feedback. The suggestions that needed action were forwarded to the relevant team leads. Many of the comments related to the long wait time for a first appointment date, but some concerned communication or the need for an evening clinic, for example.However, wait times for first appointment had not improved significantly.
- Feedback from the friends and family test in relation to musculoskeletal services had resulted in a range of actions including prioritising clearing waiting lists, reminding teams to ensure that staff are discussing patient's treatment and condition with them fully and giving them opportunities to ask questions. Services reacted to other comments by providing more car parking spaces and providing more information to GPs for example.However, many negative comments concerned waiting lists.
- The services learned from patient feedback. In 2015/2016, Springfield Road community nurses received friend and family test feedback which showed how much patients valued continuity of treatment by the same nurse. The services allocated clinics to staff on a weekly basis so that patients had more continuity.
- Leaders prioritised the participation of people who used services. The trust board in October 2016 recognised the community health services team's work in rolling out the use of ipads to increase the amount of people who were responding to the friends and family test.

Staff engagement

- The trust used Listening in Action as a means of engaging with the staff teams. One outcome listed in the trust's annual report was improved communication for community health service's night nursing team.
- Leaders and staff understood the value of raising concerns and there was a robust incident reporting culture in adult community health services.The directorate as a whole (including inpatient services) reported 627 incidents in October 2016.
- Staff could inform the trust board about new initiatives. The staff voice initiative gave podiatry staff the opportunity to present to the trust board on the improved podiatry pathway.

Innovation, improvement and sustainability

- The trust did not implement all CQC improvement actions in a timely manner. We inspected the service in March 2015 and raised the issue of ensuring teams were adequately staffed to prevent impacts on workloads due to staffing shortages. Whilst the trust had taken steps to recruit more community nursing staff nursing caseloads were still at unmanageable levels impacting on their ability to receive statutory and mandatory training. We heard at a team meeting that there were continuing problems with agency nursing staff visiting patients with needs too complex for their nursing competence level.
- The trust had arranged for a process improvement consultancy to analyse patient pathways with a view to improving capacity and lead times. This work had just started when we inspected.

Requires improvement

Are services well-led?

- The services did not use information about best practice elsewhere to improve care. We found that neither day to day service delivery nor service integration projects used learning from other trusts or organisations as part of their service planning or performance measurement.
- The trust had received funding for some innovative projects. The heart failure specialist nurses received funding for a project to help patients with obstructive sleep apnoea in chronic heart failure aiming to bridge the gap between detection and treatment. We did not see the outcomes of this work.
- The trust had an annual staff recognition award scheme known as the 'simply the best' awards.

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 18 HSCA (RA) Regulations 2014 Staffing • Insufficient numbers of nursing staff (substantive and bank nurses) had completed mandatory training in topics that were key to their role. This included the Mental Capacity Act 2005, fire safety and safeguarding. This is a breach of regulation 18

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Some community health services were not provided in a timely manner and did not meet the needs of the patients. • From March to October 2016 the unscheduled community nursing service had only met their two hour visit response target on 53% of referrals. This service did not meet the needs of the patients. • There was a failure to meet some of the referral to treatment target for patients referred to the continence service, the community therapy service and musculoskeletal physiotherapy service. This is a breach of regulation 9