East Cheshire NHS Trust

RJN

Community health services for adults

Quality Report

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

Summary of findings

Ratings

Overall rating for Community health services for adults	Inadequate
Are Community health services for adults safe?	Inadequate
Are Community health services for adults effective?	Requires Improvement
Are Community health services for adults caring?	Good
Are Community health services for adults responsive?	Requires Improvement
Are Community health services for adults well-led?	Inadequate

Summary of findings

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Summary of findings

Overall summary

East Cheshire NHS Trust provided adult community services across east and south Cheshire and Vale Royal. Services we inspected were provided in people's own homes, nursing homes, clinics and GP practices.

The trust had taken measures to increase nursing capacity. However, adult community teams experienced staff shortages and had difficulty in recruiting. Community nurses told us that there were limitations when it came to seeing emergency patients due to staffing and time pressures. Staff shortages had compromised the standard of record keeping and of the recording and investigation of incidents.

Training records showed that most community staff had completed appraisals in the last 12 months and mandatory training including training in the Mental Capacity Act 2005. However, several staff, including senior clinical staff, did not know what the term 'deprivation of liberty' meant or how to apply the Mental Capacity Act 2005 to their work.

The service did not adequately monitor the quality of service provision to identify or manage risks in order to assure people's welfare and safety. Incident reporting and investigation were inconsistent across the adult community health services. Community nurses did not always report and investigate incidents in line with the trust's incident-reporting policy. Evidence of learning from incidents in the community nursing services was also limited.

The vision for the service was unclear and staff felt that the trust was focused on hospital care rather than community services. Although staff knew who the chief executive was, they were unclear on the management structure above their immediate line manager. Most staff was unable to tell us who the director of nursing was.

Allied health professionals were unaware of which directorate they came under and some were unaware of who their next-level managers were. There was good local leadership across allied health professionals and specialist nursing teams. However, there was a lack of leadership from immediate line managers within community nursing teams. While some staff told us that the chief executive had liaised with them about the restructuring of the service, some community nursing staff felt that they did not have a voice in the organisation.

Community services for adults were unable to provide us with a clear overview of what their performance indicators were and what the outcomes were for patients. Podiatrists and physiotherapists told us that they were meeting their targets but did not have evidence of this. Staff had limited access to the trust's intelligence data or any information the trust gathered. This meant that services and the trust did not have robust oversight of the quality of services provided.

Community services delivered evidence-based practice in line with national guidance. Staff worked within their scope of practice and in accordance with the recommendations of their professional governing bodies. Across all services, care and treatment of patients were delivered with empathy and compassion. We observed staff interacting with patients in a professional and respectful manner. Staff promoted and maintained the dignity of patients when they delivered care in various community settings, such as community clinics and patients' own homes. Staff were aware of the need to be sensitive to people's religious and cultural needs. All teams were aware of the demographics in their area and how they needed to adapt the way they worked to meet the needs of patients.

Summary of findings

Background to the service

East Cheshire NHS Trust provided adult community services across east and south Cheshire and Vale Royal.

Services we inspected were provided in people's own homes, nursing homes, clinics and GP practices and included:

- Community nursing, including out-of-hours services
- Leg ulcer care
- Parkinson's specialist nursing
- Respiratory specialist nursing
- Community matron services
- Home intravenous therapy
- Podiatry
- Occupational therapy
- Audiology
- Speech and language
- Physiotherapy services.

The community nursing service is a large service and is the main provider of domiciliary nursing care for adults who have complex and palliative care needs, working in collaboration with key partners within primary care and social care. The service also provides leg ulcer clinics in a number of health centres. Community matrons provide care for patients with multiple, complex long-term conditions who are at a high risk of hospital admissions and readmissions. The service delivers assessment, diagnosis and treatment for this group of patients in their own homes, when they may otherwise have been admitted to hospital.

Parkinson's nurses support people coming to terms with their diagnosis of Parkinson's disease, offer guidance on managing medication and make appropriate referrals to other professionals such as speech and language therapists and physiotherapists. Respiratory specialist nurses and physiotherapists work together at the trust in treating patients with chronic lung conditions. They see patients in hospital, in the community, in hospital clinics and in their own homes.

The home intravenous therapy service has been established for several years. National evidence illustrates the benefits of community-led intravenous services, which facilitate a patient's early discharge from hospital to a community setting, and, where appropriate, eliminates the need for admission into hospital. The service had recently piloted new projects to expand the service into new specialities. For example, cardiology and alcohol management.

The podiatry service offers specialist service provision such as wound care, nail surgery, biomechanical assessment and orthotics manufacturing and supply. The service treats adults with foot and lower limb problems. Speech and language services provide an assessment, management and advice to adults and/or their carers regarding speech, language, fluency, voice and communication disorders as well as eating, drinking and swallowing difficulties. The adult audiology department provides hearing services for adults.

The occupational therapy department treats patients with physical illness or disability through specific activities that will enable them to reach their maximum level of function and independence. The physiotherapy service provides a musculoskeletal service. The service primarily treats adults but will accept referrals for children where the primary problem is a musculoskeletal disorder (such as knee pain).

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers

Team Leader: Helen Richardson, Care Quality Commission

The inspection team included: two CQC inspectors (one of whom has previous experience in adult community services), an advanced nurse practitioner/community matron specialist adviser and an expert by experience.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of East Cheshire NHS Trust.

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 held a listening event in Macclesfield on 9 December 2014 when people shared their views and experiences of adult community health services. Some people also shared their experiences by email or telephone. We carried out an announced visit from 9 to 12 December 2014.

During the visit we spoke with a range of staff who worked within the service, such as senior managers, team leaders, community nurses, therapists and specialist nurses. We observed how people were being cared for and reviewed care or treatment records of people who used the services. We met with people who used the services and with carers, who shared their views and experiences of the core service.

What people who use the provider say

We spoke to 29 patients who all told us how happy they were with the care and treatment provided by community staff and said that the staff were helpful and caring. Patients told us they felt that staff were "knowledgeable and always knew what they were doing". One person told us: "I am confident in the service. I know I can always pick up the phone and speak to someone if I have any concerns or questions."

Community nurses were observed having a good rapport with patients during visits and acted in a caring manner.

One patient told us: "I haven't met anyone in the team that I wouldn't want caring for me." We saw thank you cards from bereaved relatives thanking the nurses for their compassionate care.

Patients told us that staff were friendly and helpful and were always polite and respectful. One person receiving care from the community nurses told us: "I have full admiration for the nurses … they involve me in my care and answer any questions that I have … I feel safe under their care."

Good practice

- Podiatry services told us that they had recently won an award for innovation for building a prototype machine to assist people with flexing their lower limbs.
- Parkinson's nurses were offering an 'in-reach' programme that provided advice to ward staff to promote Parkinson's patients getting their medication on time.
- The home intravenous therapy service had been established for several years. National evidence illustrates the benefits of community-led intravenous services, which facilitate a patient's early discharge from hospital to a community setting, and, where

Summary of findings

appropriate, eliminates the need for admission into hospital. The service had recently piloted new projects to expand the service into new specialities. For example, cardiology and alcohol management.
- The respiratory specialist nursing team had won awards for productivity and the home intravenous therapy team had been nominated for two national awards on innovation.

- Adult community services planned and coordinated care packages for patients who needed integrated teams to provide support at home. For example, we saw patients being supported by the community nurse, occupational therapy and social services.

Areas for improvement

Action the provider MUST or SHOULD take to improve

We found evidence of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

- The provider must ensure that there are sufficient levels of staff with the appropriate skill mix to deliver services safely.
- The provider must ensure that there are appropriate, robust systems in place to identify risks and to monitor and assess the quality of services provided.

In addition:

- The provider should ensure that staff understand their responsibilities particularly in relation to incident reporting, the Mental Capacity Act and deprivation of liberty safeguards.
- The provider should ensure that staff are engaged in the strategy and vision of the service and that there is clear board visibility.
- The provider should ensure that all medicines stored in clinics are stored in line with best practice requirements.
- The provider should ensure that documentation, including the end of life care pathway used in the community, is fit for purpose and meets the needs of people who use the service.
- The provider should ensure that there is clear communication and joint working between acute and community services to ensure safe and appropriate referral and discharge.
- The provider should review the line management and professional lines of reporting within the community nursing teams.
- The provider should consider improving arrangements for clinical supervision to ensure that they are appropriate and support staff to effectively carry out their responsibilities, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.

East Cheshire NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Inadequate

Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

Adult community teams experienced staff shortages and had difficulty in recruiting. Community nurses told us they worked together to cover vacancies and sickness within teams and did not feel that these challenges immediately compromised patient safety or quality of care. However, there was limited flexibility to cope with additional sickness absence. Incident reporting and investigation were inconsistent across adult community health services. Community nurses did not always report and investigate incidents in line with the trust's incident-reporting policy. Evidence of learning from incidents in the community nursing services was also limited.

Community nursing teams used a dependency tool to determine whether caseload numbers were safe. However, it was difficult to assess whether caseloads were appropriate as the dependency assessment did not take into account the acuity of patients' needs on each caseload. This meant that there were potentially unsafe staffing levels for more than half the time during the period we reviewed. There was no evidence of any escalation or action taken. Community nurses told us that there were limitations when it came to seeing emergency patients due to staffing and time pressures. In order to ensure that all patients were seen, staff would either work overtime or delay non-urgent patients to the caseload for the next day.

The falls risk assessment and the end of life care pathway document were not always fully completed. Community nurses told us these documents were cumbersome to use and did not meet the needs of people in the community. This meant that patients were at risk of not receiving appropriate care.

Training records showed that the majority of staff had completed mandatory training which included training in the Mental Capacity Act 2005. However, several staff, including senior clinical staff, did not know what the term 'deprivation of liberty' meant or how to apply the Mental Capacity Act 2005 to their work.

Detailed findings

Incidents, reporting and learning

- Incidents were reported using the electronic incident-reporting system.
- A total of seven serious incidents were reported by the adult community health services between October 2013 and June 2014. These were in relation to 'pressure ulcers at the patient's home'. These figures were worse than average.
- Some community nursing staff told us that they did not always report incidents because they did not have the time. Staff told us that they would report what they felt it was a priority. This meant that staff were not following the trust's incident-reporting policy.
- Some teams told us that they felt inclined not to report certain incidents as they felt no one would investigate them. Senior members of the community nursing teams told us that incidents were not always investigated due to staffing shortages.
- Community nursing staff were unable to access an overview of incidents for their service. This meant that they were unable to identify possible trends and learning outcomes. Staff were frustrated that they did not receive feedback from the incidents they reported. As a result, evidence of learning from incidents in the community nursing teams was limited.
- Allied health professionals and specialist nurses told us that they were reporting all incidents.
- We spoke to a senior member of the specialty nursing team who told us that they investigated all incidents and held team meetings to learn from them. They gave us examples of learning from incidents. However, evidence that this learning had been shared throughout the adult community health services was limited.

Cleanliness, infection control and hygiene

- There was a clear infection control policy in place. Staff in all community settings demonstrated good infection control practices such as the use of personal protective equipment and regular hand-washing before and after patient care.
- Patients told us that they noticed staff would wash their hands regularly.
- Community nursing staff completed regular hand hygiene audits. However, some community nurses told us that they did not have time to go out in pairs to complete the hand hygiene audit so would monitor each other washing their hands in the office. This looked only at technique and did not provide an accurate reflection of whether staff were compliant with procedures in practice.
- Podiatrists used disposable equipment so did not need to sterilise their equipment, which lowered the risks of cross-contamination.
- In two clinics we found toys that were not washable and were being stored on the floor. This was not in line with best practice guidance.

Maintenance of environment and equipment

- The community clinics we visited were fit for purpose to deliver care and treatment.
- We saw two clinics that needed refurbishment; both were tired and in need of redecoration. For example, carpets were heavily stained and painted walls were scuffed and chipped.
- The required equipment was readily available and was fit for purpose.

Medicines management

- Community nurses administered controlled drugs through syringe drivers in line with trust policy and National Institute for Health and Care Excellence (NICE) guidelines.
- We saw that emergency medicines kept by community nurses were not always checked on a regular basis. There was also evidence of surplus stock. The nurses recognised this as an issue and planned to return the excess medication to the pharmacy.
- Some patients told us that staff did not always explain their medication to them. One person told us that they always had to look up their own medication and it would be better if the specialty nurses discussed it with them first.
- The trust had recently set up a new project for providing intravenous therapy at home. The team had developed policies and procedures based on best practice from other trusts and national guidance.

Safeguarding

- Staff knew how to recognise signs of abuse and were confident about reporting concerns.
- Data provided by the trust showed 84% of adult community healthcare staff had received level 2 safeguarding training.

- Staff provided examples of when and how they had raised alerts. They told us that they felt supported by their immediate line managers with safeguarding issues and found the safeguarding team easy to access and helpful.
- Staff working in all community clinics were aware of the need to follow up non-attendance at appointments for vulnerable patients.

Records systems and management

- Community nurses maintained paper-based records that were kept in patients' homes. Clinics held electronic records. We reviewed 13 sets of notes and found that all contained the necessary information, such as care plans and risk assessments, to allow staff to carry out the required clinical activities.
- Staff told us that the new end of life care pathway was cumbersome and as more suitable for use in a hospital setting rather than in the community. As a result, we saw few examples of it being completed in full.
- Nurses completed an initial assessment on referral to the service. However, we found that this contained limited detail and was not person-centred.
- Daily records were often task-oriented and did not provide any other details of the person's wellbeing.
- Community nurses were required to complete an electronic patient record after a visit or on return to the office. This meant that patient notes were duplicated between the home records and the electronic records. The trust was attempting to resolve this by investing in hand-held computer devices (tablets). At the time of our inspection, this initiative had not been fully implemented so had had limited impact. We saw that staff also encountered issues such as poor connectivity in the community and that most bases had no wireless internet connection and no IT support at weekends, making the use of the devices problematic.
- Staff thought that the electronic system they used for patient records was good. They told us that doctors could see details of their visits and thought that this was useful for patients' continuity of care.
- According to the care plan audit of 2013, which looked at 60 notes from six different services in the community (allied health professionals, specialist nursing service, community nursing service, and intermediate care – east, dermatology and rheumatology), 86% to 100% of notes contained consent, 98% had an initial assessment and 80% had basic identification data. However, the audit did not look at the quality or content of the notes.

Lone and remote working

- Policies and procedures were in place for maintaining staff safety when they were working alone. All community staff considered safety to be of utmost importance.
- On evening community nursing shifts, staff would contact the lead nurse to let them know they were home safely. If they had concerns regarding any of the areas they were visiting, overnight staff would visit in pairs to ensure their safety.

Assessing and responding to patient risk

- All community staff were able to confidently and correctly tell us what they would do in emergency situations.
- Community matrons held a caseload of patients at high risk with multiple, complex and deteriorating conditions. They could prescribe medication, which relieved pressure on GPs, and they saw their role as preventing people from being admitted to hospital. They told us that they used to work closely with the hospital to manage the discharge of patients effectively and coordinate their care. However, the process had been changed, which meant that patients were discharged without the team knowing; staff felt that this was a potential risk. This had been raised with the hospital but there had been no response or progress at the time of our inspection.
- Clinics had slots for emergency appointments for anyone who needed to be seen the same day.
- The falls risk assessment was not always fully completed. This meant that patients were at risk of not receiving appropriate care. The template in use at the time of the inspection was based on national guidance. However community nurses told us it did not meet the needs of people in the community and did not always accurately assess whether the person was at a high risk or not. We found that some teams were not regularly reviewing the assessment as it was lengthy and staff did not have the time.
- Community nurses told us that there were limitations when it came to seeing emergency patients due to staffing and time pressures. In order to ensure that all

patients were seen, staff would either work overtime or delay non-urgent patients to the caseload for the next day. We saw that one team collated a list of all delayed visits. This was not recorded officially so was not monitored by the trust. When we asked senior management members of the community nursing team, they were not aware that some patients had to have 'delayed' visits.

Staffing levels and caseload

- Adult community nursing teams had experienced staff shortages and had difficulty in recruiting. The community nursing (east) evening service and night service reported a turnover of 22% and 31% respectively. In addition some services reported high sickness rates. From January 2014 to July 2014, the community nursing (central) team reported sickness levels of up to 7%.
- The evening and night services were the worst affected with the (central) evening service reporting sickness rates from 23% in January 2014 to 8% in July 2014 (peaking at 26% in February). Sickness rates for the (central) night service team rose to 16%.
- An agreed action plan was in place for community services which included recruitment and sickness absence levels. However, there was limited evidence of progress.
- Use of agency staff at this time was low. For example, for the same period, the community nursing (central) evening service reported no use of bank or agency with the exception of April 2014 (5%). Community nurses told us they worked together to cover vacancies and sickness within teams and did not feel that these challenges immediately compromised patient safety or quality of care. However, there was limited flexibility to cope with additional sickness absence.
- The trust was aware of the staffing issues within community nursing services and the difficulty it had in recruiting staff. Staffing establishment was highlighted on the divisional risk register and a staffing action plan was in place. The risk was added to the register on 26 November 2013 and was due for review on 31 December 2014. The trust told us this had been reviewed regularly but there was limited evidence of progress.
- In addition some of specialist nursing teams and allied health professional teams also suffered from high staff turnover. From April to August 2014 the trust reported a staff turnover rate for the specialist continence nursing team of 14%. For the same period the trust reported turnover rate of 9% for the physiotherapy and occupational therapy (east) team.
- Community nurses completed a daily register to determine whether staffing levels were appropriate. Staff used a dependency assessment based on a rating system of green (safe patient-to-nursing ratio), amber (required monitoring) and red (unsafe). We reviewed the dependency scores for nine teams for September and half of December, which came to a total of 42 days. We found that during this period, the rating for 10 days had not been recorded, four days were rated green and the remaining 28 days were rated either red or amber. This meant that there were potentially unsafe staffing levels for more than half the time during the period we reviewed. There was no evidence of any escalation or action taken.
- It was difficult to assess whether caseloads were appropriate as the dependency assessment did not take into account the acuity of patients' needs on each caseload. For example, one nurse told us that they had eight patients to see, all of which were complex and took a lot of time. Yet as this was under the threshold of 16 patients, it was not flagged as being an issue.
- There was no monitoring of overtime or of how long people had spent with patients. Nurses completed the relevant forms but some teams told us that the forms were not reviewed. Nurses worked overtime on a regular basis and would work while having lunch. Some nurses told us that they also took work home with them on a regular basis. The aforementioned action plan was in place for community services which included recruitment and sickness absence levels. However, there was limited evidence of progress.
- Community matrons told us that they felt isolated as they were based geographically rather than within a team, so they often worked in isolation. They stated that they rarely had time to meet as a team to discuss clinical issues or share work.
- Staff told us that senior managers were aware of staffing level and caseload issues but they did not routinely report them as incidents because they felt it would not make any difference.
- All the staff we spoke with told us that they felt their caseloads were too large and they felt stressed or rushed when providing care.

Deprivation of liberty safeguards

- Local training records showed that the majority of staff had completed mandatory training in level 2 safeguarding which included training in the Mental Capacity Act and deprivation of liberty safeguards.
- However, several staff, including senior clinical staff, did not know what the term 'deprivation of liberty' meant or how to apply the Mental Capacity Act 2005 to their work.
- Community nurses signed consent forms on behalf of patients to say that they consented to the treatment. This was not in line with regulatory requirements. It did not specify on the documents what the treatment was; again, this was not in line with requirements.

Managing anticipated risks

- Out of the nine community matrons to whom we spoke, five told us that they were retiring in the near future. Whilst the trust told us there were succession plans in place; staff were not aware of these and felt the trust had not taken into account the length of time it took to bring staff in the developmental roles up to standard.
- We saw evidence from the District Nursing Action Plan 2014–2015 that the trust planned to review the staffing for community nursing and their skill mix, to review the mobile working project and to improve communication links with senior management. When we asked senior staff (band 8) about this action plan, they were not aware of any plans in place to improve the service.

Requires Improvement

Are Community health services for adults 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.

Community services for adults were unable to provide us with a clear overview of what their performance indicators were and what the outcomes were for patients. Podiatrists and physiotherapists told us that they were meeting their targets but did not have evidence of this. Staff had limited access to the trust's intelligence data or any information the Trust gathered. Following the clinical management restructure, the trust planned to develop a dashboard that would include specific indicators for the community nursing service; this would include activity, outcome measurement and quality indicators. Training records showed that most community staff had completed mandatory training and appraisals within the last 12 months. However, a training record for one of the out-of-hours nursing teams showed that, out of 30 staff, only half had completed their mandatory training and only half had received an appraisal.

There was a disconnect between community-based nursing staff and hospital staff. Community nurses and matrons felt that the hospital did not liaise well with them during the discharge of a patient into the community. They also felt that hospital staff did not promote care that could be undertaken by the patient, which led to inappropriate referrals. Senior members of the community nursing staff and matrons were unable to tell us if anything was being done to resolve these issues in order to promote better coordinated working between the two services. However, we saw numerous examples of good multidisciplinary team working. Adult community services planned and coordinated care packages for patients who needed integrated teams to provide support at home. For example, we saw patients being supported by the community nurse, occupational therapy and social services.

Community services delivered evidence-based practice in line with national guidance. Staff worked within their scope of practice and in accordance with the recommendations of their professional governing bodies. Staff were responsive when patients described being in pain and provided evidence-based advice for pain management or efficient and appropriate GP referrals. Pain relief for patients receiving palliative care was discussed at multidisciplinary meetings and plans were made for managing patients' pain control. Anticipatory prescribing was common, in line with best practice, so that pain relief and other medication could be started quickly if a patient became unwell.

Detailed findings

Evidence-based care and treatment

- Community services delivered evidence-based practice in line with national guidance, for example in the areas of wound treatment and injection techniques. Staff worked within their scope of practice and in accordance with the recommendations of their professional governing bodies.
- The trust had a range of policies and clinical guidelines available for staff. These were held on the trust's intranet and were readily accessible for staff in the community.
- All community staff used National Institute for Health and Care Excellence (NICE) guidelines and knew how to access these on the internet.
- The Parkinson's nurses, respiratory specialist nurses, physiotherapists and podiatrists networked in specialist groups; they attended regular updates where some would present their work.
- Community nurses told us that they would keep up to date by reading nursing journals in their own time.

Pain relief

- Staff were responsive when patients described being in pain and provided evidence-based advice for pain management or efficient and appropriate GP referrals.
- Patients had an appropriate pain assessment in their notes.
- Pain relief for patients receiving palliative care was discussed at multidisciplinary meetings and plans were made for managing patients' pain control. Anticipatory prescribing was common, in line with best practice, so that pain relief and other medication could be started quickly if a patient became unwell.
- Patients who were assessed as requiring pain relief and other medicines but who were unable to take them by mouth were offered other appropriate methods of administration including by syringe driver.

Requires Improvement

Are Community health services for adults effective?

Approach to monitoring quality, people's outcomes and patient outcomes performance

- Community services for adults were unable to provide us with a clear overview of what their performance indicators were and what the outcomes were for patients. Podiatrists and physiotherapists told us that they were meeting their targets but did not have evidence of this. Staff had limited access to the trust's intelligence data or any information the trust gathered.
- Following the clinical management restructure, the trust planned to develop a dashboard that would include specific indicators for the community nursing service; this would include activity, outcome measurement and quality indicators. At the time of our inspection, the only measure community nurses had was the safety thermometer dashboard. The trust provided details for pressure ulcer, venous thromboembolism, falls and catheter-acquired urinary tract infections indicators. These showed that results were better than the national average.
- Community matrons collated information to see how many hospital readmissions they had avoided. The home intravenous therapy team also kept a clear log of the number of days they had saved patients from being in hospital. Records showed that the team had saved 1,378 days in the last year.
- The community matrons knew of a prescription audit but had not received any feedback or results. They also completed a template on the electronic record system after every visit to note whether they had saved a hospital admission, but, again, they did not have the results and had not received any feedback.

Competent staff

- Training records showed that most community staff had completed mandatory training and appraisals within the last 12 months. However, a training record for one of the out-of-hours nursing teams showed that, out of 30 staff, only half had completed their mandatory training and only half had received an appraisal.
- Staff told us that they had not received adequate training in the use of the electronic records system or the electronic incident-reporting system in order to be able to use them to their full potential.
- Community nurses told us that they did not have the time to go on any additional training courses and would feel guilty leaving the team short-staffed. The nurses felt that they had a limited skill mix in the teams. We found that staff were not supported to undertake any extra training or to develop areas of specialty. The trust had a policy in place for clinical supervision but there were no consistent systems in place for clinical supervision of community matrons and nurses. The purpose of clinical supervision is to provide a safe and confidential environment in which staff can reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.
- All the allied health professionals and specialist nurses told us that they felt well supported to undertake extra training and would highlight this in their appraisals.
- Community matrons and community nurses had irregular team meetings.
- The community nurses and matrons felt that there was little encouragement to 'grow your own' senior nurses. The experience required prior to undertaking a district nursing course or being a matron was a lengthy process.
- Patients told us that they felt staff were "knowledgeable and always knew what they were doing". One person told us: "I am confident in the service; I know I can always pick up the phone and speak to someone if I have any concerns or questions."

Use of equipment and facilities

- The process for ordering new equipment was time-consuming. Community nurses told us that they would avoid ordering equipment for patients if at all possible as the process was lengthy. Nurses from various teams told us that it took roughly two hours to order a hospital bed. Junior community nurses told us that the process was so lengthy and problematic they would often ask senior nurses to complete the process on their behalf. Senior nurses told us that they had raised this with line managers and it had been escalated but they did not feel that any action had been taken.
- However, on all the home visits we attended, we saw that patients had the appropriate equipment in their homes and one member of staff did confirm that, as soon as equipment was ordered, it arrived fairly quickly.
- Community nurses completed a list every week of where all their hospital beds were; they also had to write why the patient still needed the bed. The nurse explained that the beds were all for patients who needed long-term care or were paralysed. Nurses would request

Requires Improvement

Are Community health services for adults effective?

equipment for people who were at a very high risk of developing pressure ulcers but felt it could be difficult obtaining the appropriate equipment. The nurses told us: "We have gone from being proactive to reactive."
- Physiotherapy services did not claim back equipment (such as walking frames) from patients after they had finished with it. Physiotherapy staff described this as "a drain and waste of resources".
- Signage throughout most of the clinics was not fit for purpose because signs were too high up to see and were difficult to read.

Multidisciplinary working and coordination of care pathways

- Adult community services planned and coordinated care packages for patients who needed integrated teams to provide support at home. For example, we saw patients being supported by the community nurse, occupational therapy and social services.
- We saw numerous examples of good multidisciplinary team working and allied health professionals told us that they felt well supported by community nurses.
- Physiotherapists felt that they worked well with the main hospital and had good links with orthopaedic wards.
- There was a disconnect between community-based nursing staff and hospital staff. Community nurses and matrons felt that the hospital did not liaise well with them during the discharge of a patient into the community. They also felt that hospital staff did not promote care that could be undertaken by the patient, which led to inappropriate referrals. Senior members of the community nursing staff and matrons were unable to tell us if anything was being done to resolve these issues in order to promote better coordinated working between the two services.
- Community nurses were well supported by the continuing healthcare team when arranging complex packages of care.

Good

Are Community health services for adults caring?

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

Across all services, care and treatment of patients were delivered with empathy and compassion. We observed staff interacting with patients in a professional and respectful manner. Staff promoted and maintained the dignity of patients when they delivered care in various community settings such as community clinics and patients' own homes.

Patients told us how happy they were with the care and treatment provided by community staff and said that the staff were helpful and caring. Patients were signposted to various support networks that were available. Patients' emotional wellbeing was assessed and was an important part of their treatment.

Specialist nurses recognised that a large part of their role was to provide patients and relatives with emotional support and they ensured that they never rushed patients. Staff encouraged patients to be independent and supported them to better understand their care and treatment.

Detailed findings

Compassionate care

- Across all services, care and treatment of patients were delivered with empathy and compassion.
- Community nurses were observed having a good rapport with patients during visits and acted in a very caring manner. One patient told us: "I haven't met anyone in the team that I wouldn't want caring for me." We saw thank you cards from bereaved relatives thanking the nurses for their compassionate care.
- We observed clinics with specialty nurses and allied health professionals and found that they knew the patients' social as well as medical background and had a good relationship with them.
- Patients told us that staff were friendly and helpful. Patients at clinics said that they didn't feel rushed by staff and that staff listened to them.
- All staff and patients were complimentary when describing the receptionists in the clinics. Patients told us that they were polite, welcoming, discreet and helpful.
- Most of the staff we met demonstrated a real pleasure in their work and seemed happy to be caring for patients. A lot of staff told us: "I love my job."

Dignity and respect

- Patients told us that staff were always polite and respectful.
- Staff promoted and maintained the dignity of patients when they delivered care in various community settings such as community clinics and patients' own homes.
- We saw that patients' dignity was maintained during clinical examinations.

Patient understanding and involvement

- Staff obtained consent before carrying out a procedure. Allied health professionals and nurses made sure that the patient understood the medication and advice given to them. We saw that they involved patients in the decision-making process.
- We observed the Parkinson's specialist nurse-led clinic. The nurse listened to patients and explained symptoms in a way the patient could understand. They provided advice to support patients in making decisions and empowered them to make choices about their care. One patient told us that they didn't understand the doctor when they were diagnosed but the nurse was better at explaining things in a way they could understand.
- One person receiving care from the community nurses told us: "I have full admiration for the nurses … they involve me in my care and answer any questions that I have … I feel safe under their care."

Emotional support

- In some clinics, patients told us that they had made friends and joined support networks. They told us that they felt emotionally supported by staff and by the other patients staff had introduced to them.
- We saw several thank you cards from bereaved relatives thanking community nurses for the emotional support provided during a difficult time.
- Specialist nurses recognised that a large part of their role was to provide patients and relatives with emotional support, and they ensured that they never rushed patients. They told us: "An appointment will take

Good

Are Community health services for adults caring?

as long as the patient needs. If we need to book them in again then we do so." Patients were signposted to various support networks that were available. Patients' emotional wellbeing was assessed and was an important part of their treatment.

Promotion of self-care

- We observed community nurses providing telephone advice to patients. We heard them communicating in a polite and respectful manner. One of the patients was in control of their own treatment and the staff supported them in understanding their condition.
- We observed the nurse specialist giving self-care advice to a patient. The nurse specialist was considerate and polite and held an open, honest two-way conversation with the patient and their relatives and gave them holistic support and advice. Achievable and realistic goals were set with patients.
- We observed community nursing home visits. The nurses told us that they were proud to be able to support people to stay as independent as possible in their own homes.
- Specialist nurses gave people a lot of verbal information but gave them very little written information to remind the patient of their care and treatment or supplementary information about their condition.

Requires Improvement

Are Community health services for adults responsive to people's needs?

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

'Did not attend' rates were higher than the national average ranging, on average, from 3% to 8% (January to June 2014). To try to address this, allied health professionals told us that they used a text message service to remind patients about their next appointment. Staff and patients thought this was an effective system.

Data on 18 week referral to treatment times (RTT) for community services such as the musculoskeletal clinical assessment and treatment service, audiology, pain management and rheumatology services showed these services were achieving their waiting time targets. However, it was not clear how this information was shared with the relevant teams and there were no key performance indicators for community nursing services. Feedback from individual teams was mixed. Some teams told us that they were not meeting waiting time targets due to staffing shortages, while others told us that they were meeting target waiting times and had a degree of flexibility to accommodate urgent patients who needed to be seen the same day.

Community nurses told us that the quality of discharge referrals from hospital were poor and the service received large volumes of inappropriate referrals. However, it was difficult to understand to what degree this issue was due to the inconsistency in incident reporting and a lack of quality outcome measures. It was not clear what actions the service was taking to address these concerns.

Patients who used the out-of-hours nursing service told us that this service was excellent and responded within an hour of them calling the team. They thought it was a very efficient and reactive service. Staff were aware of the need to be sensitive to people's religious and cultural needs. All teams were aware of the demographics in their area and how they needed to adapt the way they worked to meet the needs of patients. Staff were aware of the trust's complaints policy and provided examples of when they would resolve concerns locally and how to escalate them when required.

Detailed findings

Service planning and delivery to meet the needs of different people

- Staff were aware of the need to be sensitive to people's religious and cultural needs. All teams were aware of the demographics in their area and how they needed to adapt the way they worked to meet the needs of patients. Allied health professionals gave examples of how they tailored appointments to fit around the needs of patients.
- Services were tailored to the learning needs of the patient. Physiotherapy patients who were rehabilitating could access exercise classes. Patients told us that they preferred exercising with guidance and with the support of other patients.
- Allied health professionals told us that they undertook domiciliary visits for those patients who were unable to travel.
- We saw that the trust had adopted a new end of life pathway. Staff told us that it was cumbersome and had been designed for use in a hospital setting rather than in the community. As a result, we saw few examples of it being completed in full.

Access to the right care at the right time

- The trust was not collating data for any performance indicators to see how quickly urgent patients were seen. Community nurses told us that they did not have the flexibility to accommodate urgent visits and would have to delay non-urgent visits until the next day.
- Patients who used the out-of-hours nursing service told us that this service was excellent and responded within an hour of them calling the team. They thought it was a very efficient and reactive service.
- Allied health professionals and specialist nurses covered several clinics across Cheshire and patients could choose between different locations for some clinics in order to reduce travel.
- 'Did not attend' rates were significantly worse than the national average ranging, on average, from 3% to 8% (January to June 2014). To try to address this, allied health professionals told us that they used a text message service to remind patients about their next appointment. Staff and patients thought this was an effective system.

Requires Improvement

Are Community health services for adults responsive to people's needs?

- Most patients waiting in clinics told us that they had not had to wait long once they arrived for their appointment.
- Patients told us that the booking system for appointments took a long time before anyone answered. One person told us: "More often than not I am tenth in the queue."
- The trust collated data on 18 week referral to treatment times (RTT) for some community services such as the musculoskeletal clinical assessment and treatment service, audiology, pain management and rheumatology services. The community business group integrated performance data pack for July 2014 showed these services were achieving their waiting time targets. However, it was not clear how this information was shared with the relevant teams and there were no key performance indicators for community nursing services.
- Feedback from individual teams regarding RTT was mixed. Speech and language, audiology and one respiratory clinic told us that they were not meeting their targets due to staffing shortages, but they did not have the figures available to support this. Community matrons told us that they averaged three people on their waiting list, which they felt was manageable, although one told us that she had 19 people waiting to be seen. Parkinson's specialist nurses, the home intravenous therapy team, podiatry, physiotherapy and thoracic nurse specialists told us that they were meeting target waiting times and had a degree of flexibility to accommodate urgent patients who needed to be seen the same day.
- General Practitioners we spoke to in the area raised concerns regarding the responsiveness of the district nursing in being able to see patients in a timely manner.

Discharge, referral and transition arrangements

- Community nurses told us that the quality of discharge referrals from hospital were poor, which led to nurses having to chase information. We reviewed discharge notes from hospital and found that they contained insufficient detail, were not person-centred and were difficult to understand. It was not clear what action had been taken to try to address this matter.
- Community staff told us that the discharge 'home before lunch' scheme had been implemented but was not happening in practice. The out-of-hours nursing service confirmed this. We saw that there were a number of incidents that were related to out-of-hours discharge. The trust recognised this as an area for improvement.
- Community matrons told us that the acute hospital staff no longer liaised with them during discharge, and, as a result, they felt that there was no continuity of care for patients requiring care in the community.
- Community matrons had a text message system to alert them when people were admitted to hospital but there was no equivalent service for people who had been discharged. This had been escalated appropriately. They hoped that the service would be implemented soon, although they had not received confirmation.
- Community nurses felt that they received a large number of inappropriate referrals from the hospital and GPs. Community nursing managers told us that this had been resolved, although staff told us it remained an ongoing issue. However, it was difficult to understand to what degree this issue was due to the inconsistency in incident reporting and a lack of quality outcome measures and indicators. The out-of-hours nursing service and community matrons told us that they did not receive inappropriate referrals and felt they responded to appropriate patients most of the time.

Complaints handling and learning from feedback

- Formal written complaints were collated centrally by the trust and investigated appropriately. We saw that there had been only one formal complaint in relation to community services for adults and this had been resolved. We asked all services if they had received any other complaints. Only one community nursing team was aware that it had missed a patient visit; the complaint letter had gone to the GP but had not gone to the trust's complaint log. This meant that the trust did not have clear oversight of all complaints received in relation to adult community health services.
- Staff were aware of the trust's complaints policy and provided examples of when they would resolve concerns locally and how to escalate them when required.
- There was no system for recording informal verbal complaints. For example, community nurses received verbal complaints about the discharge process but did not record these as complaints or comments.
- The audiology department disseminated battery issue cards to each patient that included the details of how to

Requires Improvement

Are Community health services for adults responsive to people's needs?

make a complaint. We did not see any information on making a complaint about adult community healthcare services in any of the other clinics or health centres that we visited.

- We saw comment cards available in some of the allied health professionals' clinics we visited. Patients who had visited allied health professionals told us that they had completed the feedback surveys sent out by the trust. Patients told us that they did not know how to complain but would ask a receptionist.

Inadequate

Are Community health services for adults 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.

Although staff knew who the chief executive was, they were unclear on the management structure above their immediate line manager. Most staff were unable to tell us who the director of nursing was. Allied health professionals were unaware of which directorate they came under and some were unaware of who their next-level managers were. There was good local leadership across the allied health professionals and specialist nursing teams. However, there was a lack of leadership from immediate line managers within community nursing teams. This was mainly because team leaders were also carrying caseloads due to staff shortages and the demands placed on the service. As a result, community nurses felt unsupported.

The vision for the service was unclear and staff felt that the trust was focused on hospital care rather than community services. While some staff told us that the chief executive had liaised with them about the restructuring of the service, some community nursing staff felt that they did not have a voice in the organisation.

There were no consistent quality measures or key performance indicators for community services. This meant that services and the trust did not have robust oversight of the quality of services provided. Safety thermometer data was collated but the results and any action points were not fed back clearly to the relevant teams. There were no effective systems in place for capturing and managing risk. For example, a daily staffing levels register completed by community nurses showed there were potentially unsafe staffing levels for more than half the time during the period we reviewed. However, there was no evidence of any escalation or action taken. Staff were not following the trust's policy for incident reporting and investigation. This meant there was a risk of incidents being under-reported and incidents were not always investigated due to staffing shortages.

There were examples of innovation within individual teams. Parkinson's nurses offered an 'in-reach' programme that provided advice to ward staff to promote Parkinson's patients getting their medication on time. The respiratory specialist nursing team had won awards for productivity and the home intravenous therapy team had been nominated for two national awards on innovation.

Detailed findings

Vision and strategy for this service

- The trust was aware of the most significant challenges and risks within community services and had plans in place to address them. These challenges included understaffing within nursing as a whole and the introduction of new technology to improve record keeping and data collection across the county.
- The vision for the service was unclear to staff and they felt that the trust was focused on hospital care rather than community services.
- Community nurses wanted to be more involved in shaping and influencing the future of the service but some told us that they felt they did not have a voice in the organisation.

Governance, risk management and quality measurement

- There were no consistent, clear quality measures or key performance indicators for each community service. This meant that services and the trust did not have robust oversight of the quality of services provided.
- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm-free' care and for recording pressure ulcers, falls, catheters and infections. Staff told us that they completed the monthly safety thermometer audit. However, we found that the results were not fed back to teams so there was limited evidence of quality measurement or improvement at a local level.
- The trust completed an annual care plan audit. However, the audit focused on whether documents were present in patient records but did not sufficiently review the quality of notes. This meant that it did not identify issues such as incomplete falls risk assessments or the limited use of the end of life care pathway.

Inadequate

Are Community health services for adults well-led?

- There were no effective systems in place for capturing and managing risk. For example, a daily staffing levels register completed by community nurses showed there were potentially unsafe staffing levels for more than half the time during the period we reviewed. However, there was no evidence of any escalation or action taken.
- The community nursing services had issues with inappropriate referrals, poor discharges, duplicate records and the ordering of equipment. They had raised all these issues with their managers but felt they had no reassurance from managers that something would be done about their complaints.
- Staff were not following the trust's policy for incident reporting and investigation. This meant there was a risk of incidents being under-reported and incidents were not always investigated due to staffing shortages.
- The trust completed general surveys and comment cards but did not feed this information back to individual services.
- Community matrons completed audits but they had not received feedback from the trust regarding results or identified learning.
- The home intravenous service calculated how many bed days it saved the trust and fed this information to the board on an annual basis.

Leadership of this service

- Staff were unclear about the management structure above their immediate line manager. Staff did not know who the board members were and felt that they were not visible. Allied health professionals were unaware of which directorate they came under and some were unaware of who their next-level managers were.
- All staff knew the name of the chief executive and most staff were aware that he contributed to a blog on the hospital website.
- There was good local leadership across the allied health professionals and specialist nursing teams. However, there was a lack of leadership from immediate line managers within community nursing teams. This was mainly because team leaders were also carrying caseloads due to staff shortages and the demands placed on the service. As a result, community nurses felt unsupported.
- We found that community matrons (band 8a) were being directly line managed by band 7 team leaders, which both found an uncomfortable situation. As a result, community matrons did not feel adequately supported. When discussed with the director of nursing she appeared unaware of this.

Culture within this service

- Community nurses all had a good working relationship with one another within their own teams. They spoke freely with one another and felt that the senior nurses (band 6) were all friendly and approachable.
- Staff were dedicated, caring and professional. This was evident throughout all the teams we inspected.
- The out-of-hours nursing service told us that some of the board members visited them and had been out on visits.

Public and staff engagement

- Some staff told us that they attended the chief executive's workshops to better understand what was going to happen during the restructuring. Most of the community nurses were unaware of these workshops.
- Some community nurses felt that they did not have a voice in the organisation. They felt that the trust had not engaged with them on several aspects of their day-to-day working.
- Community nurses and community matrons did not give out any comment cards nor were they aware whether their patients were asked to complete surveys by the trust. They told us that they did not formally monitor patient satisfaction but relied on informal feedback from patients during visits. We saw that informal feedback was provided by patients on a day-to-day basis but this was not recorded anywhere so it was unclear to staff how satisfied patients were with the service.

Innovation, improvement and sustainability

- Community matrons told us that they attended the trust awards ceremony. The trust provided evidence that community services were recognised as part of this ceremony. However, staff felt as though the majority of awards went to the hospital staff and they did not feel the community services were recognised.
- Podiatry services told us that they had recently won an award for innovation for building a prototype machine to assist people with flexing their lower limbs.

Inadequate

Are Community health services for adults well-led?

- Parkinson's nurses were offering an 'in-reach' programme that provided advice to ward staff to promote Parkinson's patients getting their medication on time.
- The respiratory specialist nursing team had won awards for productivity and the home intravenous therapy team had been nominated for two national awards on innovation.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were insufficient numbers of staff to meet the needs of people and keep people safe. Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and other staff working in adult community services to meet the needs of service users. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010: Staffing.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The service did not adequately monitor the quality of service provision to identify or manage risks in order to assure people's welfare and safety. There were no quality measures or key performance indicators for the community services. This meant that services and the trust did not have robust oversight of the quality of services provided. Incident reporting and investigation were inconsistent across the adult community health services. Community nurses did not always report and investigate incidents in line with the trust's incident-reporting policy, which meant that there was the potential for under-reporting. Regulation 10(1)(b) HSCA 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision.