Great Western Hospitals NHS Foundation Trust

RN3

Community health services for adults

Quality Report

Great Western Hospital
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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)
RN325	Great Western Hospital		SN3 6BB

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core serviceGOOD

Overall we rated all these adult community services as good. The trust provides a range of community services including district nursing, physiotherapy, continence, podiatry, wheelchair services, learning disability services, dietetics, diabetes, respiratory,adult speech and language therapy, neurology and tissue viability. During the inspection we looked at community services for adults, community outpatients and diagnostic services.

We rated all the five domains of this core service as good and found that some aspects of the effective and well led domains were outstanding.

The community services had a commitment to providing harm free and safe care. There were procedures in place to improve pressure care treatment through staff training and also the use of new innovative treatment techniques.

We found there were robust procedures in place for reporting incidents and staff we spoke with were aware of the processes to follow. We saw the learning from incidents was cascaded and improvements were initiated.

Equipment was well maintained and clinics and patient waiting areas were kept clean hygienic and safe.

Staff were completing mandatory training. The integrated health team was 80% compliant with mandatory training. which met the trust target of of 80%. Infection prevention and control mandatory training was completed by 85% of the team.

There were relevant and current evidence based guidance and best practice in use by clinicians across all the various services. We considered some of this to be outstanding practice. We found some outstanding practice where clinicians accessed information and knowledge through colleagues, clinical networks and professional associations.

Staff we spoke with said they considered that the trust valued training and they, “felt invested in”. Staff told us the training was generally of a high standard, was well planned, organised and professionally delivered.

Staff received annual appraisals and there were excellent levels of support from colleagues and managers. All staff we spoke with said they were well supported and supervised by their line manager. However there were inconsistencies around the arrangements for clinical supervision.

There were numerous examples of positive, professional multi-disciplinary working. We considered some of these to be examples of outstanding practice. This occurred within the integrated teams, between the county wide specialist teams, with GP surgeries and with hospital based clinicians. Staff were able to demonstrate knowledge of the various other professionals they worked with, how they shared information and also sought advice and support from different specialists.

Patients were treated with kindness, dignity respect and compassion by the clinical staff and also by reception and other staff working when they visited the community hospitals.

Various developments and changes in the planning and delivering of community services had taken place over the previous 18 months. There was a drive to implement integrated Integrated Teams to work closely around primary care to make care accessible to patients as locally as possible. The Integrated Teams provided a seven day service between 7am and 10 pm. The out of hours service between 10pm and 7am was commissioned to a private provider.

We saw and heard about various initiatives in place to improve the service to patients, including pressure care treatment, multi-disciplinary working with acute colleagues and early intervention treatment for stroke patients.

Patients living in the community were able to access care and treatment in a timely way, though there were some breaches of the 18 week national referral to treatment target in certain services. Action plans were in place to address the shortfalls in breaching these targets

Staff were well informed about the strategy for community services. They were able to explain the values and objectives, such as working closely with primary care services, providing a holistic service, promoting healthy lives and working in an integrated team of professionals.

Summary of findings

There was a governance framework in place which gave clear guidelines over lines of responsibility. There were clear processes in place to monitor quality and risk and deliver an improving service. We found that there were some outstanding examples of auditing and action planning against identified shortfalls or areas for improvement by the different Integrated Teams and specialist county wide services.

The leadership and culture reflected the vision and values of the trust and encouraged staff engagement with delivering quality community based services. We found examples of outstanding leadership being provided by heads of locality and the clinical leads for the specialist services.

There was a culture of teamwork that permeated through the community adults service.

There were examples of services taking action to promote improvement and best practice and to improve the service delivered to the community. We saw examples of outstanding and innovative ideas being put into action.

During the inspection we spoke with approximately 70 staff, including managers, clinicians, administrators, technical staff and domestic staff. We also spoke with the trust director for community services.

We spoke with 39 patients and relatives. We visited locations across the geographical area where services were run and also where they were managed and coordinated. We observed care and support being provided by clinicians both in clinics and in the patients own homes. We ran drop in session in the three community hospitals where staff could talk to inspectors.

We looked at a sample of patients records and also trust documentation, including training records, policies, monitoring data and risk registers.

We took feedback from the public via our website and through public listening events. We also received feedback through the healthwatch organisation who had sought the views of patients.

Summary of findings

Background to the service

Information about the service

The community services are delivered through six main community hospitals and also from other locations such as health centres, primary care centres and GP surgeries across Wiltshire. Some specific services were also delivered by arrangement from Salisbury District Hospital and Royal United Hospital Bath.

Services were provided to adults in community based settings or in their own homes. The services were focused on providing planned care, rehabilitation following illness or injury, ongoing and intensive management of long term conditions and management of care for people with complex needs and health promotion.

There were three localities whose managers reported to the director of community services. Within these localities there were core services that included the community nursing and integrated care teams, of which there were twenty in total. There was also county wide therapy, rehabilitation and intermediate care teams. Outpatients and diagnostic services were run at the six community hospitals.

The range of services provided included audiology, community neuro, and integrated teams for learning disabilities, epilepsy, fracture clinic, physiotherapy orthotics, urology, wheelchair services, lymphedema and x-ray.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop, Senior Medical Advisor, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included of 58 people included 17 CQC inspectors and a variety of specialists: A retired chief executive, a director of nursing, a safeguarding specialist, a paramedic, a senior sister in emergency medicine, a consultant surgeon, a consultant in anaesthesia, a consultant neonatologist, a consultant in paediatric palliative care, a consultant haematologist, four community matrons, a health visitor, a speech and language therapist, two physiotherapists, an occupational therapist, specialist nurses in end of life care, medicine and maternity, a junior doctor, a student nurse and an expert by experience.

Why we carried out this inspection

We conducted this inspection as part of our in-depth inspection programme. The trust was identified as a low risk trust according to our Intelligent Monitoring model.

This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

How we carried out this inspection

For this inspection we visited a range of settings where staff were based and also clinics in which patients received care and treatment. We looked at records, policies and other data relating to the services delivered. We went with clinical staff on patient visits; we spoke with patients and their relatives.

We looked at data collected and supplied by the trust and also received direct feedback for the general.

Prior to the visit we ran public listening events for the general public to share their views and during the inspection we distributed comment cards for people to complete if they chose to.

Summary of findings

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out our visits on the 29 September to the 2 October 2015. We also carried out an unannounced visit on 15 November 2015

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?

What people who use the provider say

People who used the community services told us the staff were caring and professional. We were told patients were treated with respect and felt involved in their care and treatment and staff were responsive to questions and queries about treatment.

The Friends and Family Test (FFT) is a feedback tool which offers patients of NHS-funded services the opportunity to provide feedback about the care and treatment they have received. The results of monthly friends and family tests were displayed throughout the community Integrated Teams bases. Results in a number of locations showed that 100% of patients asked would recommend the service to friends and family.

During our inspection visit we spoke with 39 patients and their relatives. Everyone we spoke with was complementary about the approach and professionalism of the staff they came into contact with. Comments made included, "she's an angel, they look after me so well it's wonderful," "I look forward to the visits they are always polite and kind," and " I've got no complaints I could not fault any of the nurse who have visited me."

Good practice

- We saw evidence of outstanding multi-disciplinary working. For example the neurology community team worked with a patient, their carers, social services, housing authorities and other clinicians including the palliative care team to arrange the adaptation of accommodation for a patient with motor neurone disease.
- The wheelchair service committed to providing wheelchairs for patients diagnosed with motor neurone disease within two weeks by prioritising the adaptations that were required to be completed. They also provided a priority service for patients who were receiving end of life care.
- We heard of some outstanding practice in the community respiratory team that ensured the latest guidance was followed and that practice was as informed as possible. A clinical lead for COPD (chronic obstructive pulmonary disease) explained how they were a member of the Primary Care Respiratory Society, who forwarded the latest guidance from NICE. They were also a member of the Respiratory Nurse Association that circulated information to all its members. They had recently given a presentation to a group of fifty GPs and practice nurses on advice about the new medicine management algorithm for COPD management. They had arranged for two other speakers, a consultant and a pharmacist to present information as well at this meeting about the latest practice that was being developed. There were weekly teleconferences and meetings every six weeks between colleagues to discuss the latest guidance. Other initiatives included organising a days training for specifically for physiotherapists and brief informal training updates to nursing teams during their lunchbreaks. We were also given an example of the latest guidance from NICE that was out for

Summary of findings

consultation around asthma which was being reviewed by the team. The lead nurse also chaired quarterly meetings of a respiratory network of health professionals who worked in respiratory services.

- The tissue viability team led by a nurse consultant demonstrated an outstanding level of evidence-based practice and innovation in the management of pressure ulcer care. Regular, quarterly pressure ulcer audits contributed to a quality improvement collaborative for pressure ulcers work plan and the organisational action plan for pressure ulcer reduction. The new system was being rolled out across the county at the time of inspection. An estimated £40,000 a year was expected to be saved due to the reduction in the length and frequency of nursing visits, with time saved to be used to visit more patients. Great Western Hospital is the first provider nationally to roll out the use of these systems.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure that the policy for clinical supervision is clear and understood by all staff.
- Ensure that all staff receives regular clinical supervision
- Take steps to improve the referral to treatment times for the community continence service so that patients are seen within 18 weeks of their referral.

Great Western Hospitals NHS Foundation 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 domain as good.

The community services had a commitment to providing harm free and safe care. There were procedures in place to improve pressure care treatment through staff training and also the use of new innovative treatment techniques.

We found there were robust procedures in place for reporting incidents and that staff we spoke with were aware of the process to follow. We saw the learning from incidents was cascaded and that improvement was initiated.

Equipment was well maintained and clinics and patient waiting areas were kept clean hygienic and safe.

Staff received safeguarding training as part of their induction programme. The trust used an electronic system to monitor staff training. 94% of staff had completed safeguarding vulnerable adults mandatory training which exceeded the trust target level of 80%.

Patient records were up to date and completed in detail by clinical staff. The trust was transferring to an electronic recording system which would improve access to information for staff.

Staff were completing mandatory training. The integrated health team was 80% compliant with mandatory training which met the provider's target of 80%. Infection prevention and control mandatory training was completed by 85% of the team.

Procedures and arrangements were in place to anticipate and manage any disruption to services caused by seasonal issues, such as the weather, or issues due to staffing sickness or shortages.

Detailed findings

Safety performance

- We judged that overall harm free care was being provided in line with national averages. With the provider having in place a range of safety performance measurements undertaken on a regular basis to enable monitoring of trends and incidences.

Good

Are services safe?

- We saw that there were initiatives in place to improve the performance around the management of pressure care, including staff training and also the use of innovative procedures. One such procedure was an alternative to the use of four layer bandaging called JuxtureCure, which was being use to help with peripheral vascular disease.
- Other steps to improve pressure care management included the sharing of guidance with carers around best practice and pressure care tools in a package called the "skin bundle". The patient safety and quality lead chaired a county wide harm free care group which disseminated information to the various teams and specialist services. This group had organised a patient safety quality day where a wide range of professionals were invited. A range of topics were covered which included mental capacity, safeguarding, non-concordance and tissue viability. Two staff we spoke who had attended said the information exchanged was excellent and had also improved the networking of staff throughout the area.
- The NHS safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. The provider monitored safety thermometer indicators including pressure ulcers, VTE's and falls on a monthly basis and used a quality dashboard to analyse key performance indicators. These showed that pressure ulcers grades 3 and 4 were low and declining over the last 6 months April to August 2015. Grade 2 pressure ulcers increased slightly during the same period. However, staff told us the reporting of grade 2 pressure ulcers had improved during this time. The total number of pressure ulcers developed on the integrated team's caseload was low and fell during the last 6 months April to August 2015. The development of category 3 and 4 pressure ulcers was low at an average of 1 per month. The overall incidence was 0.7% during 2014-2015 compared with 3% estimated nationally.
- The community Integrated Teams monitored the safety thermometer indicators relevant to their area of work. For example the tissues viability nurse reported back to their team about the latest data regarding pressure ulcers rates. In each locality base staff had access to an electronic monitoring dashboard which provided that latest safety data for their particulars service and area.
- The total numbers of patient falls in the community team, which includes patients at home on the district nursing caseload, fell during the previous three months June to August 2015. On average, the number of falls was compliant with the providers key performance indicators throughout 2014-2015.
- Venous thrombo-embolus risk assessments record whether the patient has had a risk assessment documented and is a recognised quality standard. These assessments measured persistently high scores achieving the provider's key performance indicators throughout 2014 to 2015 year to date.
- Senior members of the integrated teams informed us that key themes from the friends and family test and the safety thermometer test were reviewed at monthly team meetings. We saw posters which displayed these results throughout the Integrated Teams, and very high scores were attributed to the friends and family test. In most teams 100% of patients would recommend the service to friends and family.

Incident reporting, learning and improvement

- There were robust procedures in place for reporting incidents. We spoke with a range of staff including those who were working in the outpatient departments in the community hospitals and found they were in the process to follow and had been trained in how to use the electronic reporting system.
- We spoke with a deputy head of locality who described the incident reporting process. Incident reports were put through on an electronic, online form referred to as an IR1. If the incident was a medication error as well as a notification going to the risk escalation team who coordinated reports, a note would also go to the medicines manager representative. If there was a pressure ulcer included in the IR1 it would notify the tissue viability nurse. Whenever an IR1 was raised it automatically included the deputy head of locality and the integrated team leader. The issue would be investigated and considered at a panel for learning. It was considered at the meeting whether it needed to go on the corporate risk register or could it be resolved there and then.
- A total of 1450 incidents were reported in relation to adult care in the community between July 2014 and June 2015. Of these 1348 were reported by the

Good

Are services safe?

Integrated Teams, most of which would have occurred in the patients home, but not all. These were reported as 661 being no harm, 576 as being low harm, 77 as moderate, 14 as severe, 20 near miss. In total 92% of incidents resulted in no harm or low harm to the patient. There had been no never events recorded. Between April 2014 and May 2015 there were 37 serious incidents reported by the Integrated Community Health Division (ex inpatient wards) . Of these 37 were incidents that occurred in peoples own homes and 97% of these related to the reporting of pressure ulcers A deputy head of locality explained that IR1s were broken down into teams and were analysed for learning. This happened at locality and patient safety meetings which were held monthly. All incident reports were seen by the appropriate team manager and locality manager. Themes were discussed with heads of the three localities and feedback was provided to the staff member, or the team manager, following the reporting of an incident. We were told of another example of learning from this process. A low incidence or reporting of issues relating to medicines management was identified within the medicines management team. As a result, the deputy head and team were looking at this issue to understand if there was cause for concern due to potential underreporting.

- We were told by team leaders in the district nursing teams and therapy services that incident reports submitted were reviewed monthly to identify any trends and to share learning within teams. All staff we spoke with told us there was a 'no blame' culture and that incident reporting was encouraged and viewed as an opportunity for learning.
- Staff we spoke with informed us that incidents reported on the electronic recording system (IR1) were discussed at every monthly team meeting and themes were reviewed. At an Integrated Teams meeting we heard incidents being discussed and learning shared between teams and we reviewed evidence of this in meeting minutes. One example was an incident reported by a district nurse following a concern about the management of patient in receipt of palliative care. The information had been shared with all the professionals involved, including the GP, and the subsequent learning shared.
- Managers explained how they would escalate information and also share the feedback through team briefings and supervisions. We saw examples of root cause analysis carried out following the reporting of incidents. These reports included information from all the professionals involved, and the subsequent findings were shared.
- A clear pressure ulcer incident investigation process was in place for all category two to four pressure ulcers. Any investigations and learning from categories three to four pressure ulcers, which are deemed as more serious, were presented at a harm free care focus group to determine whether further escalation and reporting was required.
- A Commissioning for Quality and Innovation payment (CQIN) spot check monitoring tool for 2015-2016 was used to review sets of patients' notes to identify whether pressure ulcer risk assessment tools were being completed for patients seen in the community, and whether avoidable hospital admissions were being achieved. We examined several sets of audits of the spot check monitoring tool and saw that all assessments were effectively completed by staff.
- We spoke with staff about their understanding and knowledge of the new statutory duty of candour. Staff were able to articulate the meaning of the regulation and were aware of how to follow the process correctly. On the electronic incident reporting system, a mandatory duty of candour page had been added in order to prompt staff to follow the appropriate actions in line with the guidance for incidents which met the criteria. The relevant information was then recorded for each incident. A duty of candour policy had been in place since July 2015. We heard examples of how the process was followed appropriately and learning shared with wider teams.

Safeguarding

- There were reliable systems, practices and processes in place to keep people safe and safeguard them from abuse.
- Staff received safeguarding training as part of their induction programme and staff we spoke with confirmed that had completed this training. The provider used an electronic system to monitor staff

training which feeds into a governance database. 94% of staff had completed safeguarding vulnerable adults mandatory training. This exceeded the provider's target level of 80%.

- Staff we spoke with gave us examples of how they had reported safeguarding incidents and concerns. At an Integrated Team meeting we heard an example of how a safeguarding concern was raised and managed effectively in line with the provider's policy.
- Lead members of staff were identified within teams for staff to talk to if they had any concerns around safeguarding. These staff were called "practice influencers." We heard during an integrated team meeting from a nurse in this role and about their training. Learning was shared and as a result, extra training, in addition to mandatory training, was identified for the team.
- We spoke with a podiatrist who was trained as a 'practice influencer' and was planning to raise the profile of mental capacity and safeguarding within their team in the forthcoming team meeting. They gave examples that would cause them to be concerned and request further advice or information before referring to safeguarding. For example, repeated missed appointments or the appearance of 'neglect' both when patients attended clinics and in their own homes.

Medicines

- The arrangements for managing and storing medicines and supporting patients with medicines management promoted safety.
- Some patients were given self-management plans which were reviewed with the patient regularly by the nursing staff. This included guidance on which medicines to take and when. Some patients were given a visual stimulation aide to use in order to support concordance with medication.
- In two outpatient departments we visited we saw drug cupboards were locked and secured. The drug fridges were also locked and displayed a temperature of four degrees centigrade, which fell within the appropriate temperature range. The fridges were checked daily and temperatures recorded and signed. There were no inappropriate contents, such as specimens in the drug fridge. We checked a sample of drugs and saw they were in date. In one department we were shown a box of resuscitation medication for treating anaphylaxis or allergic reactions. This was locked securely, the contents were in date and routine checks were completed.

Environment and equipment

- The maintenance and management of equipment used by staff and patients and the environment staff worked in promoted and ensured their safety.
- We found adequate stocks of equipment were securely stored. Staff told us replacement stock was ordered and delivered promptly. Equipment was located at various community hospitals and health centre locations. This meant in general, staff could access what they needed from the base where they worked.
- There were systems in place to log equipment in and out of the store which ensured traceability.
- A deputy head of locality led a county-wide group for the purchasing of clinical equipment. This group was responsible for ensuring the quality of equipment and that appropriate governance processes were in place. Examples of this included new types of dressing being used, and protective clothing being purchased.
- Servicing and cleaning of equipment was completed, recorded and audited in order to keep people safe. For example in the wheelchair service centre a new audit system was introduced which ensured supplies were dated and logged and cleaning recorded. A system was also put into place which ensured stock was well organised and easily accessible.
- We looked at two sets of resuscitation equipment located in patient waiting areas. These were correctly stored and the appropriate checks were completed and recorded by staff who were specially qualified to do so. In one outpatient department we observed a staff member perform the weekly check on the resuscitation equipment. The defibrillator was working correctly and equipment for resuscitation was present and in working order. A paediatric bag, valve and mask that helped patients to breathe was out of date (8 August 2015). When tested though, it was fully functioning. Staff had reported this and the equipment was awaiting replacement.

Quality of records

Good

Are services safe?

- We found records were stored safely, though nursing staff told us that records in the patients own homes were sometimes mislaid by the person concerned. Community services were in the process of moving to electronic record keeping and the staff training for this was ongoing at the time of our inspection visit.
- We looked at sample of 12 patient records. We found these were up to date and correctly signed where appropriate. Records contained risk assessments, nutritional and hydration assessments, pressure ulcer assessments and completed care plans. Where required there were pictures of pressure ulcers, measurements and descriptors. We saw dementia screening tools were used and records of this in the notes. Names and contact details for all clinicians involved in a person's care were recorded.
- Patients had copies of their records in their homes and were encouraged to keep these safe and accessible. In some of the work bases we saw how patients' records were stored securely in lockable filing cabinets within rooms with key coded doors. However, at one location the storage room did not have a coded lock and some of the cabinets inside were not locked. Staff informed us a request was made for a coded lock but there was an ongoing discussion as to whether this was a maintenance or buildings improvement concern. This meant records could be accessed by the public as the room was located in the entrance to the health centre building.
- In the outpatients department records were stored in the correct location and were always within sight of a member of staff. Confidentiality of records was maintained.

Cleanliness, infection control and hygiene

- We visited a total of six clinic areas, five staff offices and three outpatient areas. We saw that these areas were clean and well maintained, with several clinic rooms having been updated and decorated in the last two years. The areas we saw were clean and hygienic with infection control audits undertaken by the senior manager of the particular location. Patient waiting areas had sufficient seating and patients we spoke with told us they had no concerns about cleanliness whenever they visited the department or clinic.
- Clinicians we spoke with said they were confident about the quality of cleaning of the clinic rooms. Rooms were cleaned regularly and thoroughly with the appropriate recording documented. We spoke with the receptionist at one of the health centres where outpatients attended. They had responsibility for overseeing the cleaning contract that was run by an outside contractor. They regularly checked the work completed and had a process for reporting any shortfalls when clarification over the standard required was needed.
- All utility, clinic and waiting rooms where clean and tidy. All chairs in the waiting room had wipe clean surfaces and were intact. There were adequate supplies of disposable gloves and aprons readily available.
- All clinical staff had completed infection control training but the trust data for the annual update was at 79.6%, with the trust target for this being 80%. We observed staff correctly following procedures whilst with patients, both in clinics and in patients homes. There were clear arrangements for the disposal of waste products in the base locations and also guidance for staff to follow when in patients' homes. In the outpatients departments safe arrangements were in place for managing waste and clinical specimens. All the waste bins had the correct colour bag in them. All the bins checked were either empty or had the appropriate class of waste in them. Waste was segregated and stored in a separate room labelled 'dirty utility'or 'clean utility'.
- Teams were proactive in promoting and improving good hygiene procedures. During an integrated team meeting, the results of an internal hand hygiene audit were discussed. On one occasion, staff were found to be wearing jewellery. This had been raised within the meeting as a point of learning from the audit. Staff had responded to the information by creating a new uniform and dress code based on safety and infection control. Feedback from staff highlighted how hands could become sore from the use of hand sanitising gel during the colder months. In response, a new type of hand sanitising gel was purchased to ensure staff were compliant with hand hygiene policies.

Mandatory training

- Staff were aware of their responsibilities to complete mandatory training. A database was kept within the

trust which monitored compliance with mandatory training and teams were informed of any shortfalls. The integrated health team was 80% compliant with mandatory training which met the provider's target.

- Training targets in almost all staff roles within the community were not met for adult basic life support training and infection prevention and control. Managers told us how they were working toward improving the completion rates. Increased training was booked and staff were monitored through their annual appraisals to ensure the required training was completed. During one Integrated Team's meeting, we heard how adult basic life support training had been cancelled in the summer but was now all rebooked. Mental capacity and deprivation of liberty training was below the target of 80%, at 77.1% for registered nursing staff and at 63.3% for unregistered nursing staff. It was also reported during this meeting that some mandatory training, including this, was being done but not marked as completed within the providers' reporting system.
- We looked at the information dashboard in one the locality offices. We saw evidence of mandatory training and appraisal compliance for one area team, Marlborough, which was at 90%. Where compliance was below 80% a reason was given. For example one team achieved 78.9% compliance, this was due to difficulty in accessing online resources for mandatory training as it was in a building owned by another agency. Reasons for figures on dashboards not reflecting what people had actually completed were attributed to a delay in the training tracker taking time to update the system. This was corroborated by other managers, such as the lead muscular skeletal podiatrist. Any member of staff could see their own record and that of teams on the system.
- We spoke with staff in an outpatient clinic about statutory mandatory training. They showed us certificates of training they had completed and explained that there were four subjects due to be completed shortly. We were shown the staff rota with the dates and subjects already entered on it. These were advanced conflict resolution, the yearly update for basic life support, fire training and manual handling, safeguarding children level three, and paediatric basic life support. All were due to be completed by the end of November 2015.

Assessing and responding to patient risk

- Staff completed risk assessments for all newly referred patients. This included a risk assessment of the patient's environment in order to identify risks to the patient and any adaptations or equipment required. This also ensured staff safety. Risk assessments were also completed for nutrition and hydration, tissue viability and pressure ulcers.
- New or increasing risks were reported back to the other members of the team or to other clinicians who had an involvement with the patient. This information was disseminated at the daily team briefings or at handovers from other shifts or the out of hours service.
- There was a daily conference call with the acute partners which categorised the risk in relation to active capacity management. Reassessing and reprioritising caseloads helped the team manage work load and assisted in discharge planning for patients in the acute hospital.

Staffing levels and caseload

- Managers and staff we spoke with told us that caseloads were fairly and effectively distributed. Managers reviewed and discussed caseloads in team meetings and with staff individually. Staff we spoke with said they could discuss any issues they had with their capacity and workload with their manager and they would be supported to address any problems. The Integrated Teams rarely used agency staff and had a low use of temporary staff.
- A new staffing tool, a capacity management tool was implemented in the community in August 2015. Numbers of visits and staffing workload were reviewed on a daily basis, by looking at staffing levels and workload diaries. In one of the largest teams, work load was above capacity at the time of inspection, but was being achieved by nurses working extra hours or staff being borrowed from neighbouring teams where possible. Therapists accessed a similar tool but worked to waiting lists.
- In one team where staff turnover was high, we were informed how the recruitment and advertising teams responded rapidly to vacancies and how nearly all vacancies were quickly filled.

Good

Are services safe?

- The trust had implemented a new policy of training band 5 nurses up to band 6 to help with the difficulty of recruiting fully qualified district nurses. However it took years to complete this training so was yet to have a substantial impact.

Managing anticipated risks

- Procedures and arrangements were in place to anticipate and manage any disruption to services caused by seasonal issues, such as the weather, or issues due to staffing sickness or shortages.
- We heard of an example from the Pulmonary Advice and Community Exercise (PACE) team of how they adapted the service during the month of December in order to be able to respond to patients during this time, for example, patients who had fallen or who were increasingly breathless during the winter period.
- Staff members told us about different lone working arrangements. For example the specialist physiotherapist described the lone working buddy system as 'phoning in to out of hours nurse service' as they often work after 17.00. The dietician described the lone working buddy system for when working in community and how it worked. This involved details of patient visits being held in a diary which could be checked by a buddy. The worker would communicate by text when leaving to go home. If no text was received by the buddy they would escalate this to manager. This process was corroborated by the head dietician.
- Clinical leads identified the key risks in their service to the delivery of patient care. For example, the head of podiatry described: waiting times for appointments, integration into the community nursing teams and the links with the diabetes service, as priorities for their service. The head of diabetes identified: the numbers of patients getting late insulin, the training of band 3 team members who would be mentored by band 6s, to administer insulin for stable patients, in addition to the lack of availability of places for patients on the type II diabetes structured education programme.

Major incident awareness and training

- Managers we spoke with were aware of the responsibility to respond to major incidents and staff were aware of the need for flexibility in poor weather conditions..
- We were told of a water supply problem in Wootton Basset, where business continuity plans were enacted. Staff utilised the electronic systems to identify vulnerable patients and then notify the council who provided water to community patients.
- We heard how in one part of the county during a drought, vulnerable patients were identified using the patient electronic record system, and water was taken to patients by Integrated Teams.
- We were told of the on-call manager test exercise Sahara and the exercise NHS England run (exercise Bugle) which tests lines of communication to heads of localities in the event of a major incident.
- The provider sent emails to staff regarding winter planning and advice as to how to work safely during the winter months. Vulnerable patients were prioritised and contact made with families where possible to provide more support to patients.
- The provider had pool cars and all-terrain vehicles in place for use during snow, floods or drought, in order to access vulnerable patients. A Resilience Officer acted as a coordinator for vulnerable patients during a disaster and provided plans to manage these patients.
- Staff were required to complete a form stating if they had access to a four wheel drive vehicle in case of poor weather. During last winter heavy snow resulted in staff working from their nearest community location. A coordinated approach from managers and the Integrated Teams meant that all essential visits had been completed during this period.

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 the effective domain as good and found there were some examples of outstanding practice.

There were relevant and current evidence based guidance and best practice in use by clinicians across all the various services. We considered some of this to be outstanding practice. We saw some outstanding practice involving clinicians accessing information through colleagues and managers and lead clinicians seeking out and researching information nationally through various networks and professional associations.

The Integrated Teams completed a number of audits around clinical care and collected data and information about their services which fed into their quality dashboard and also the individual locality action plans.

Staff we spoke with said the trust valued training and they "felt invested in". Staff told us the training was generally of a high standard and was well planned, organised and professionally delivered.

Staff received annual appraisals and told us there were excellent levels of support from colleagues and managers. However there were inconsistencies in the arrangements for clinical supervision. Some staff had regular formal arrangements in place whilst for others, the frequency was less predictable. There was some inconsistency around the format and frequency of one to one supervision for staff and for some staff, there was a lack of clarity around the trust policy on both clinical supervision and one to one professional supervision and development.

There were numerous examples of positive, professional, multi-disciplinary working. We considered some aspects of this to be examples of very good practice. This occurred within the integrated teams, between the county wide specialist teams, when working with GP surgeries and with hospital based clinicians. Staff were able to demonstrate knowledge of the various other professionals they worked with, how they shared information and also sought advice and support from different specialists.

Peoples consent to care and treatment was sought in line with legislation and guidance as staff had received appropriate training and had access to colleagues with more specialised knowledge.

Detailed findings

Evidence based care and treatment

- Relevant and current evidence-based guidance and best practice was in use by clinicians across all the various services. We considered some of this to be very good practice. We saw some outstanding practice where clinicians accessed information from colleagues, managers and lead clinicians. They sought information and research nationally, using various academic networks and professional associations. There were various systems for cascading new information and learning through team meetings and multi-disciplinary contact.
- We observed a physiotherapist and an occupational therapist complete assessments on patients. We saw these were holistic assessments that were completed with the full involvement of the patient. The details were recorded in the patient record. This included an assessment of any risks, for example around getting into bed, using the toilet and if the environment contributed to the risk of falls.
- Specialist teams were able to demonstrate how their care was evidence based and up-to-date. For example, respiratory specialists followed British Thoracic Society (BTS) and The Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines.
- We heard of some outstanding practice in the community respiratory team that ensured the latest guidance was followed and that practice was as informed as possible. The clinical lead for chronic obstructive pulmonary disease (COPD) explained how they were a member of the Primary Care Respiratory Society, who forwarded the latest guidance from NICE. They were also a member of the Respiratory Nurse Association that circulated information to all its members. They recently gave a presentation to a group

of 50 GPs and practice nurses on advice about the new medicines management algorithm for COPD. They arranged for a consultant and a pharmacist to present information at this meeting about the latest practice being developed. There were weekly teleconferences and meetings every six weeks between colleagues to discuss the latest guidance and current practice. Other initiatives included organising a day's training specifically for physiotherapists, and brief, informal training update to nursing teams during their lunchbreaks. We were also given an example of the latest asthma guidance from NICE that was out for consultation and was being reviewed by the team. The lead nurse chaired quarterly meetings of a respiratory network of health professionals who worked in respiratory services.

- The continence specialist team gave two examples of recent NICE guidance that had been disseminated through their team at team meetings. The continence service manager met with a national group of continence specialists twice a year and was part of an email network of specialists who shared practice issues and developments.
- The latest NICE guidance for Parkinson's disease was issued in 2005. The service was reviewed against this guidance in 2012 by Parkinson's UK and found to be fully compliant. The clinical lead nurse explained that this guidance was currently being reviewed by NICE.
- The tissue viability team led by a nurse consultant demonstrated an outstanding level of evidence-based practice and innovation in the management of pressure ulcer care. Regular, quarterly pressure ulcer audits contributed to a quality improvement collaborative for pressure ulcers work plan and the organisational action plan for pressure ulcer reduction. Areas of good practice and action plans were shared with the Integrated Teams and the patient safety and quality group. A study was conducted within two community nursing teams to assess two new types of adjustable compression device for venous leg ulcers. As a result of using the new system, patients' feet no-longer needed bandaging. This meant a return to normal footwear, improved stability and movement. Legs that were previously 'wet' and odorous dried out, self-care improved, and pain was reduced. Patients returned to activities that were previously made difficult due to the bulky nature of multi-layer compression bandages. We heard some outstanding examples of how patients' quality of life and psychological welfare improved as a result of this practice. One patient commented: "Great, I can go and visit my son tonight". This patient was then able to walk in their garden, begin driving and doing their own shopping again. The new system was being rolled out across the county at the time of inspection. An estimated £40,000 a year was expected to be saved due to the reduction in the length and frequency of nursing visits, with time saved to be used to visit more patients. Great Western Hospital is the first provider nationally to roll out the use of these systems.
- The wheelchair service had an action plan in place to support working towards the standards of the National Wheelchair Alliance initiative "right chair right time right now".
- There were a number of clinical non-medical prescribers in post and locality heads told us the trust were committed to training more.

Nutrition and hydration

- Patients had nutritional and hydration assessments completed as part of their initial assessment and these formed an integral part of their care plans. We saw evidence that these were reviewed and updated as part of their treatment and care.

Technology and telemedicine

- At the time of inspection, the provider did not use any telemedicine technology. However, staff referred patients to the 'help to live at homes service'. Four care companies were chosen by Wiltshire council and the NHS to provide this service to support older people to enable them to live at home. This service used equipment such as lifelines, pendant alarms, smoke detectors, carbon monoxide detectors and other devices, which helped patients to remain safe at home, twenty-four hours a day.

Patient outcomes

- The Integrated Teams completed a number of audits of clinical care and collected data and information about their services which fed into their quality dashboard and the individual locality action plans.

Good

Are services effective?

- We saw audits for continence care and different physiotherapy clinics. There was ongoing auditing and monitoring of pressure care, particularly in reference to the new type of treatment that was being implemented
- The provider shared a patient's story, outcome and learning in its September monthly quality report. This patient was initially assessed during a joint visit by occupational therapy and physiotherapy, and was successfully managed by the community neurology team. The patient achieved their personal goals and became independent with personal care.
- We heard a number of clear examples of how patients on the community therapy team's caseload achieved their goals and were successfully discharged from their care.

Competent staff

- Staff we spoke with were positive about the training that was provided. There was an imbedded programme for band 5 nurses to train up to band 6. This also involved staff moving round teams which helped with their professional development. Each banding had a competency framework in place which were bespoke to each profession but with some cross cutting professional competencies.
- Several staff we spoke said the trust valued training and they felt invested in by the trust. Staff told us that the training was generally of a high standard and was well planned, organised and professionally delivered.
- The continence team provided training to other clinicians. For example, they could sign off the training for catheter care for other nurses. They also ran a bowel care course and a continence assessment course for the elderly. A new four day community induction programme for new staff was introduced in July 2015. This was supplementary to the corporate induction that all staff also undertook. This was intended to promote the understanding, ethos and core values of the community services division. The aim was to better equip staff for community working, particularly for those who had no prior experience of working in the community.
- We were provided with evidence from some teams that peer supervision had been infrequent but were now being scheduled more regularly. Appraisals were on track, with those not done being scheduled
- We saw evidence in some teams we visited that appraisal rates were 100%. In other teams the rate was lower but action was being taken to improve the efficiency of this. Managers had changed the planning of appraisals so these could be staggered over the whole year rather than completed in a three month window. Other action taken included the running of monthly group supervisions for some integrated teams. We saw that there was a set agenda which included governance and clinical issues. An attendance register for these meetings was kept and staff who could not attend were updated by their line manager of issues they needed to be aware of.
- Staff we spoke with were positive about the appraisal process and all staff we spoke with had an appraisal within the last 12 months. A dietician we spoke with had had an appraisal in the last 3 weeks. They say they had good support from their manager who was based in a different area but they were able to email them regularly with queries and had formal supervision every three months.
- There were inconsistencies in the arrangements for, and frequency of, clinical supervision. We found staff were receiving clinical supervision but sometimes this was in a group format and there was not a regular structured arrangement for this. All staff we spoke with said they were well supported and could access clinical supervision if an urgent need arose but several staff said they were unaware of the trust policy or guidance. We found there were arrangements in place when individual supervision was difficult to access for group supervision to take place. Some therapy staff commented they would benefit from more professional leadership. The three lead professionals for physiotherapy, podiatry and dietetics told us they had weekly meetings with their locality lead.
- Staff we spoke with said they were well supported and supervised by their line managers but there were inconsistencies around the delivery of one to one

supervisions. Some staff had regular meetings alongside clinical supervision, and some staff were had group supervisions and only had one to one meetings with their manager for their annual appraisals.

Multi-disciplinary working and coordinated care pathways

- There were numerous examples of positive multi-disciplinary working. We considered some aspects of this to be examples outstanding practice. This was within the integrated teams, between the county wide specialist teams, with GP surgeries and with hospital based clinicians. Staff were able to demonstrate knowledge of the various other professionals they worked with, how they shared information and also sought advice and support from different specialist. All staff we spoke with very positive about their contact and multi-disciplinary working arrangements across the community wide services.
- A deputy head of locality explained how they now met monthly with GP surgeries in their area and felt this had led to improved understanding and working.
- We heard in team meetings how the Integrated Teams worked alongside GP practices, the named nurses for the practice and social services. They met regularly to look at ways in which they could improve care for patients in Wiltshire. For example, in one area, a workshop was run where a broad mix of internal and external staff had attended in order to improve patient care. A further workshop had been set up for the following month in order to build relationships with external providers of care. We heard of another example of how staff, teams and services worked together to deliver effective care and treatment, where two working groups were established to reduce hospital admissions for patients with COPD (chronic obstructive pulmonary disease). The aim was to improve the relationships between internal and external teams, and to keep the patient well and at home. They also looked at effective medicines management, which included patients' compliance with medication and inhaler technique.
- District nurses and therapists had access to nhs.net email accounts. This enabled them to liaise with healthcare professionals outside the organisation in order to benefit patient care. For example, some clinical specialists told us they used this to update GP's when they had seen a patient or to request further support for that patient, in a timely way.
- Integrated Teams worked closely together in order to ensure patients were seen by the most appropriate staff teams and supported each other with patient visits where necessary. Clinical specialists such as the respiratory clinical teams, were able to complete risk assessments such as MUST and PURAT assessments. These are assessments of a patients'nutritional and hydration needs, and a tool to identify patients at risk of pressure ulcers. This meant that the number of patient visits were minimised and risks to the patient were more likely to be identified.
- We heard how nurses met regularly with local practices. For example, the Integrated Teams teams had good access to GP practices and regularly attended practice meetings. They were able to discuss complex patients as well as share training with practice nurses and GP's, and update practice teams with new guidance and protocols on a regular basis. We heard how physiotherapists from the PACE team (Pulmonary Advice and Community Exercise) were able to make joint visits with the Integrated Teamss in order to train clinicians to give advice to patients regarding breathlessness, as this was identified as something that staff lacked skills in.
- Physiotherapy teams demonstrated effective multidisciplinary team working with internal and external teams. We observed a multidisciplinary team meeting, with the neuro-physiotherapy, physiotherapy and neuro-occupational therapy team. They met every two weeks to discuss all patients on their caseloads, newly referred patients and to arrange joint visiting appointments, in order to share knowledge and skills. Physiotherapy staff explained they met regularly with GPs and some staff met weekly with consultants in the acute trust who worked in the spinal orthopaedic department. One staff member attended some surgery MDT meetings in the acute trust where previous cases were often discussed. This was described as an excellent learning experience. Quarterly meetings were held with the radiology department.

Good

Are services effective?

- Integrated Teams extended some training to care agencies, care homes and nursing home staff. This meant that patients would be better cared for in their own environment and were less likely to be inappropriately referred or admitted to hospital.

Referral, transfer, discharge and transition

- Staff worked well together to plan and deliver effective care when patients moved between teams or services. This included undertaking timely and coordinated assessments, sharing appropriate information and following clear protocols. The Integrated Teams worked closely and effectively with GP practices and had regular access and input to GP surgery meetings. Each surgery had a named nurse they could liaise with in the community. GP Surgeries had meetings for "at risk" patients, where clinical leads and the integrated team could attend in order to ascertain who was the most appropriate clinician to support the patient.
- Referrals systems were organised to minimise delays for the patients. Healthcare professionals were able to signpost patients to or other services or healthcare professionals, as appropriate. For example a district nurse seeing a patient could refer them to occupational therapy, physiotherapy or liaise effectively with their GP.
- Nurses referred patients directly to the continence service and each integrated team had a nurse with a specialist interest in continence that was linked to the continence team.
- The wheelchair service received referrals from GPs, consultants and therapists who were accredited. Initial referrals could be made by phone as it was possible to send out chairs which did not need modifying quickly. A duty clinician was available every morning to deal with referrals so they could quickly assess the amount of modification that was required.
- The RAG (Red, Amber, Green) status community capacity tool was used in the daily conference call that took place between the acute units and community providers. This active capacity management which involved reassessing and reprioritising patients, helped the community team manage their workload, and assisted with discharge planning for patients from the acute hospital.
- The learning disability service team had nurses who liaised with acute staff when a person with learning disabilities was due to be discharged from hospital. Staff in the team were also provided with discharge planning training.

Access to information

- The information and recording systems in place supported the delivery of high quality and effective care. Information was shared effectively between professionals and also with patients.
- All information needed for patients' ongoing care was shared appropriately, in a timely way and in line with relevant protocols, when people moved between teams and services. This meant patients' information was more accurate, referral protocols were followed, and admissions avoidance could be improved. We heard how gaps were identified and improvements made, in order to ensure staff, teams and services work together to deliver effective care and treatment. For example, we were told how information about a patient had not been effectively recorded by a GP. As a result, the patient was not treated in a timely way and had to be admitted to hospital to be cared for. An investigation was carried out by the Integrated Team, and a member of the team went back into the GP practice to train staff, in order to improve the referral process.
- Patients had a set of notes in their homes which could be accessed by a variety of healthcare professionals. Records in use by Integrated Teams were completed in different formats dependent on their role. For example, the district nursing team recorded notes into patients' records and care plans within their homes, as well as on the provider's computerised patient record management system. However, this meant that staff had to duplicate record keeping and were dependant on being able to access a computer back at base. For some staff, patients' notes also had to be faxed to the GP.
- A new computerised patient record system was being introduced and was already in place in some localities. The longer term plan was to use hand held devices for all staff to access which would avoid the duplication of note writing, however there was no set date for this being rolled out. Staff told us that the recording of notes into the electronic patient record system was often

briefer that those in patients homes. This meant if patients notes in the home were lost, only a limited amount of information would be available in order to continue ongoing care.

- Staff in the outpatient departments had access to the information they needed through the electronic patient record and patients' paper records which had been requested. These were checked the day before a patient attended clinic. When records arrived they were checked for relevant information before being placed for use by clinic staff.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- People's consent to care and treatment was sought in line with legislation and guidance. Staff had received appropriate training and accessed support from staff with more specialised knowledge where needed.
- We heard examples of how patient consent was sought. We looked at a sample of four patients notes completed by a dietician. We saw these had consent plans that had been completed and dated. We saw evidence in the notes of consent being discussed and best interests being recorded.
- Staff told us they had completed mandatory training. There was two stage capacity assessment and best interest decision record form available online for staff to use with patients.
- A dietician explained how they would seek advice from their manager or other lead professionals if they were unsure of any issues around mental capacity or deprivation of liberty safeguards (DoLS). They outlined some of the key points of what might constitute a DoLs, for example did the patient have capacity to consent to care and treatment and what were the least restrictive care plans. They told us about the use of pictures and prompts they used when working with people who had language or learning difficulties.
- Staff in the learning disability team received training in the mental capacity act. We were told of an example were an independent mental capacity advocate (IMCA) was sought and appointed by a practitioner. This was to support a person who may have required an operation but needed a best interest decision to be made prior to any procedure.
- A podiatrist we spoke with explained that most patients had the capacity to consent to treatment, as it involved the patient making a number of decisions to travel to the clinic following attending a GP appointment. Generally capacity is assumed (as per Mental Capacity Act 2005). If they were accompanied by someone this could prompt them to ask questions as to why they are attending and for home visits. The podiatrist had been trained as a 'practice influencer' in safeguarding and was raising the profile of mental capacity and safeguarding within their team.

Good

Are services caring?

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

Summary

We rated the caring domain as good

Patients were treated with kindness, dignity respect and compassion by the clinical staff and also by reception and other staff working when they visited the community hospitals.

Staff from different teams who we heard coordinating the care of patients, demonstrated how they were involving patients and those close to them and recognising when they needed further support. Staff recognised when patients and carers needed support from other services.

Detailed findings

Compassionate care

- Patients were treated with kindness, dignity respect and compassion by the clinical staff and also by reception and other staff working when they visited the community hospitals.
- The Friends and Family Test (FFT) is a feedback tool which offers patients of NHS-funded services the opportunity to provide feedback about the care and treatment they have received. The results of monthly friends and family tests were displayed throughout the Integrated Community Health Division. Results in a number of locations showed that 100% of patients asked would recommend the service to friends and family.
- A comment from the FFT was shared within a team meeting: "Matron goes about her work in a friendly way and does not talk down to me."
- A Pulmonary Advice and Community Exercise service (PACE), which provides rehabilitation to patients with chronic lung conditions, particularly Chronic Obstructive Pulmonary Disease, was available at a number of locations across the provider. We saw feedback from patients who had used this rehabilitation service. One patient described how they felt, "200% better than before," and thanked staff for their, "tolerance, understanding and thoughtfulness."
- During one team meeting, staff talked in a sympathetic and caring way regarding a patient they were caring for. This member of staff had taken their own jigsaws to a patient, in order to help with the patient's rehabilitation need to improve fine finger control.
- The clinical lead nurse for neurology and movement disorder explained how they worked with the consultants in the acute trust to try and ensure they were present when a patient received their diagnosis, as this was such a life changing event that could be a traumatic experience.
- During our inspection visit we spoke with 39 patients and their relatives. Everyone we spoke with was complementary about the approach and professionalism of the staff they came into contact with. Comments made included, "she's an angel, they look after me so well it's wonderful," "I look forward to the visits they are always polite and kind," and " I've got no complaints I could not fault any of the nurse who have visited me."
- Patient feedback from other sources commented upon how helpful staff were on the phone and how patient and polite they were when sorting out appointments queries. We were also told how helpful and friendly the reception staff were in the outpatient department and the reception areas of the community hospitals.

Understanding and involvement of patients and those close to them

- Staff from different teams who we heard coordinating the care of patients, demonstrated how they were involving patients and those close to them and recognised when patients and carers needed support from other services. Examples of this are signposting emotional support from counselling services, and training carers to practice rehabilitation techniques on patients they were caring for.
- We observed occupational therapists and physiotherapist visiting patients and saw they worked in a collaborative and informative manner. Patients were encouraged to develop their independence skills. Staff communicated the relevant information about the

patient prognosis, the exercises to be carried out and any potential problems. All patients we spoke said they felt supported by clinical staff and that treatment and care pathways were clearly explained. One patient told us "they always listen to us and involve us in all the decisions that are needed". Other patients told us how staff had given them information pamphlets and taken the trouble to go through them and ensure they understood the treatment plan.

- We observed a diabetic nurse agreeing a care plan with a patient in their home. They discussed aims and outcomes, the effects of infection and the need to increase their insulin as a result. The clinician engaged with the patient and ensured that all the information was understood.
- All clinicians had a range of information leaflets they were able to give to patients to increase their understanding of their condition and the associated treatment. These leaflets were clearly written using plain English and were available in large print, Braille, easy read formats and other languages.
- A patient and their partner told us they felt they could call the community team at any time and discuss any concerns about their care and treatment. They told us, "It's really reassuring to know you have the telephone number".

Emotional support

- As part of a physiotherapy team meeting, we heard how treatment and care plans were centred around the patients' needs and their self-identified goals. The Integrated Teams consistently provided support to patients to promote self-care and independence. They told us, and we saw on visits, patients were given lots of education and support to feel enabled and empowered to manage their own health and care in order to maximise their independence.
- Patients were provided with details of how to contact healthcare professionals during out of hours. Mobile phone numbers were given to patients in exceptional circumstances, such as some patients at the end of their lives, or who suffering with long term lung conditions. This enabled patients and carers to feel reassured during difficult times.

Good

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 the responsive domain as good.

There had been various developments and changes in the planning and delivering of community services over the previous 18 months. There had been a drive to implement integrated Integrated Teams working closely around primary care and which were accessible to patients as locally as possible.

The Integrated Teams provided a seven day service between 7am and 10 pm. The out of hours between 10pm and 7am service was commissioned to a private provider. This service also provided the referral service for the Integrated Teams so was able to coordinate any issues that needed to be handed over to the Integrated Teams.

We saw and heard about various initiatives in place to improve the service to patients, including pressure care treatment, multi-disciplinary working with acute colleagues and early intervention treatment for stroke patients.

The services took account of the needs of patients who may be in vulnerable circumstances. For example the learning disabilities team provided training in the care of adults with learning disabilities who had dementia. This was accredited training that was delivered to care staff working with adults in the community, both in care homes and supported living settings. Each team in the community had identifiable dementia champions who helped to raise awareness locally and acted as a conduit to information-sharing. A dementia friendly towns initiative was set up in Calne. The provider was involved in working with the Alzheimer's society, local social groups and Wiltshire Council as part of this project.

Patients living in the community were able to access care and treatment in a timely way, though there were some breaches of the 18 week national referral to treatment target in services. Action plans were in place to the shortfalls in breaching these targets.

There was a single point of access phone line for patients and professional to use, but GPs and clinicians could also make referrals via email. The phone line was staffed from 7am every morning and urgent referrals could be handed onto the relevant community team or specialist. All urgent referrals were seen within the designated target times.

We saw examples from within the Integrated Teams demonstrating learning from complaints. We saw information on how to make a complaint was included within information packs given to patients.

100% of complaints in the Integrated Teams from August 2014-2015 were of low to medium concern and were closed within the set time frame of 25 working days.

Detailed findings

Planning and delivering services which meet people's needs

- Various developments and changes were implemented in the Integrated Community Health Division during the previous 18 months before our inspection. Integrated Integrated Teams divided into three localities, covering the whole county were in place. We were told a key objective was to provide a service that was "wrapped around" primary care services and provided as far as possible in the communities were patients lived. We were provided with examples of how community rehabilitation teams, clinical leads and district nursing teams worked effectively together within the integrated team to ensure the most appropriate staff provided care and treatment to patients with complex needs. This meant patients care visits were not duplicated unnecessarily and that individualised care and treatment was delivered. Staff were trained to carry out assessments and support colleagues in different professions. For example, a respiratory clinical lead seeing a patient following a referral could also carry out a full clinical initial needs assessment. This meant that in many cases, patients did not have to wait for a further referral to be made in order for their care needs to be met.
- Working alongside the Integrated Teams in each locality there were specialist 'county wide' teams. These included for example, the continence service and the wheelchair service.

Good

Are services responsive to people's needs?

- The Integrated Teams provided a seven day service between 7am and 10 pm. The out of hours between 10pm and 7am service was commissioned to a private provider. This service also provided the referral service for the Integrated Teams so was able to coordinate any issues that needed to be handed over to the Integrated Teams. Clinical staff and managers we spoke with said the system worked satisfactorily with any ongoing or urgent issues were communicated effectively to the staff who worked the following day. Patients and their families who received end of life care were given the direct number of the out of hours provider to use in the event of an emergency.
- A number of programmes have been developed in order to deliver care closer to home. For example, the PACE (Pulmonary Advice and Community Exercise) programme was initially a limited service for patients with long term lung conditions. It was reviewed two years ago in line new evidence. This showed the number of programmes available to patients should increase and the accessibility of services should be improved, in particular to capture patients who had recently been admitted to hospital due to their lung condition. As a result, the provider increased its provision of the service, making it available at other locations. A service for patients with conditions such as bronchiectasis, a condition which leads to a build-up of excess mucus which can make lungs more susceptible to infection, was also being satellite in different hospitals to improve access to the service.
- Following a pilot initiative, a new oxygen service had been in place since January 2015. This meant patients who require oxygen therapy or are receiving end of life care, can be managed at home.
- The physiotherapy service had initiatives in place to improve the service to patients. They had started an "active health" scheme, in conjunction with local GPs which could lead to subsidised gym membership for patients for a limited period. They ran some training for staff from the private gyms to help inform staff to be able to promote how the referred patients could be best supported through their rehabilitation whilst using the gym facilities.
- Physiotherapy were also increasing the role of extended scope practitioners, which are band 8 physiotherapist who have undertaken additional competencies. There was a pilot scheme in place which enabled some GP referrals to be triaged by an extended scope practitioner and then be referred directly for surgery. This saved the patients an additional visit to the hospital for a meeting with the consultant and decreased the waiting time for the required surgery. The pilot was being run in conjunction with consultants from a hospital run by another trust. If successful there were plans to extend the service across the county. This new clinical pathway would mean that some patients needing a total knee or hip replacement could be directly listed for their operation without the need for an interim hospital visit.
- The wheelchair service, as part of an action plan working to responding better to patients needs completed assessments that considered the patient's whole environment. These integrated assessments completed with other professionals, considered the possibility of adapting the environment as well as, or instead of, the wheelchair.
- A joint consultant clinic was run to support stroke patients as part of an early intervention programme to enable rehabilitation. The acute team contacts the appropriate community team to discuss the patient and their needs. Together they agree a suitable discharge date and the community team will review the patient within twenty-four hours of being discharged.
- Some clinical staff told us that accessing psychological support for patients was now not always easy as there were no psychologists based within the teams. This could present problems with supporting patients who were housebound and had difficulty accessing services at the acute hospitals.
- The community team had access to 10 beds in a nursing home for patients who did not require acute care but still needed time for rehabilitation under supervision before returning home. Patients could remain in these beds for a two week period.
- Diagnostic imaging facilities were located in the five community hospitals and were operational on a sessional basis throughout the week. This ensured patients needing these facilities did not have to travel to the acute hospital. Patients who used the x-ray service told us they rarely had to wait when attending for an appointment and their results were given to the clinician or their GP within a short time period.

Good

Are services responsive to people's needs?

Equality and diversity

- Staff had access to policies and procedures to ensure equality and diversity was respected during the provision of health services to patients. All staff were required to complete mandatory training in equality and diversity. The integrated team achieved 78% compliance with this training, which fell just short of the trust target of 80%.
- A notebook of translation services was available for staff to access this service and was accessible via the provider's intranet.
- A population of travellers were identified as a hard to reach group within the locality. Involvement from care coordinators to access this group of patients was being considered at the time of inspection.
- Patients' different needs were considered as part of their initial assessment.

Meeting the needs of people in vulnerable circumstances

- The services took account of the needs of patients who may be in vulnerable circumstances.
- The learning disabilities team provided training in the care of adults with learning disabilities who had dementia. This was accredited training delivered to care staff working with adults in the community, both in care homes and supported living settings.
- Staff in the learning disability service were provided with positive management training. This was accredited training that was updated and renewed every two years. This supported staff to meet the needs of adults who may at times present challenging behaviours.
- We saw signs in the outpatient departments offering chaperones for patients who required them during a consultation. The staff in the department explained how the system worked and that there was enough staff to ensure chaperones were available.
- Integrated Teams used a new Rockwood frailty tool as part of a CQUIN. The aim of this was to help identify patients who were frail in order to avoid falls and hospital admissions, and to deliver more tailored care to these patients. Falls clinics were run in different ways throughout the county and provided support for patients who had been identified as at risk of falling. Patients at risk of falls had a holistic assessment of their needs and were supported by a multidisciplinary team approach to patient management.
- In working closely with the local authority and GP practices, it was identified that the use of alcohol had increased in older age groups. As a result, teams underwent training from the drug and alcohol service and new patient leaflets were available for the team to discuss with appropriate patients.
- A STAR award was awarded to a member of staff for supporting staff to better record information onto the computerised database regarding patients living with dementia. A STAR award relates to the provider's values of service, teamwork, ambition and respect.
- Each team in the community had identifiable dementia champions who helped to raise awareness locally and acted as a conduit to information-sharing. A dementia friendly towns initiative was set up in Calne. The provider was involved in working with the Alzheimer's society, local social groups and Wiltshire Council as part of this project. They aimed to make the public more aware and tolerant towards people living with dementia. Care coordinators from within the Integrated Teams were involved in work with dementia cafes. Whiteboards which displayed safety thermometer data throughout Integrated Teams also showed dementia screening, assessments and referral targets being met.

Access to the right care at the right time

- Patients living in the community were able to access care and treatment in a timely way, though there were some breaches of the 18 week national referral to treatment target in some services.
- There was a single point of access phone line for patients and professional to use but GPs and clinicians could also make referrals via email. The phone line was manned from 7am every morning and urgent referrals could be handed onto the relevant community team or specialist. All urgent referrals were seen within the designated target times.
- The continence team were completing urgent referrals within two weeks but some non urgent cases were waiting up to 22 weeks. The waiting time had been affected by staff sickness and there had also been an

increase in the referral rate over the previous two years, caused partly by the inclusion of children on their waiting lists. There had also been a "did not attend rate" that had reached 12% at one point over the previous 12 months. Action to address this, including text reminding and referrals back to the GP had reduced this to 5% in September 2015.

- Referrals to the program of All-inclusiveCarefor the Elderly and COPD patients were seen in 18 weeks or less. Patients who have previously been seen by a respiratory clinical lead were able to re-refer themselves back to the team, for example if they required advice as to when to start taking medication if they were feeling unwell due to their lung condition.
- The diabetes team responded to routine referrals within 6 weeks. Any urgent referrals would be responded to on the day or at latest the next day. The team said there were some delays in referrals from general practice. The delay was linked to some GP's not having a practice nurse in post.
- The physiotherapy service were working on an improvement plan, drawn up in conjunction with the clinical commissioning group, that was in place. The average wait for routine referrals for the service was 6.9 weeks, having come down from 9-10 weeks. All acute and urgent wait referrals were responded to in under two weeks.
- The integrated teams contained staff who work as care co-ordinators. This role was carried out by both clinical and non-clinical staff. The role was designed to enable GPs and community nursing teams to support patients who may need a mixture of health and social care. We saw an example of a patient with a range of conditions, including depression, anxiety and Parkinson's disorder being visited by a care co-ordinator. They were also a frequent attender at their GP surgery. The care co-ordinator discussed a number of issues with them including their medication, their care package and the equipment they were using in their accommodation. If required referrals to other clinicians were discussed. Feedback was later provided to the patient's GP about the visit. The flexibility in this approach helped provide some patients with a more responsive and co-ordinated service where their needs were responded to more rapidly.
- In podiatry referral to treatment time was completed within 18 weeks for 95% of referrals with 45% of the 95% seen within 11 weeks. We spoke with two patients who were waiting for their podiatry appointments. One had been sent an appointment a week after attending a GP appointment, the other had received a telephone call at 10.30 that day as there was a short notice cancellation appointment which they were then able to attend.
- We checked that patients appointments were being booked after podiatry sessions and we saw evidence this had been done for the two patients we had spoken with in the clinic that morning. Where we saw a discrepancy we pointed this out to the podiatrist who rectified it. We also pointed this out to the podiatry lead who said they were planning to put in a mandatory field in the new electronic system record to prevent this in future.
- The neurology community nursing service responded quickly to support patients who were diagnosed with motor neurone disorder. After diagnosis rapid follow up appointments were made and patients were supported to attend specialist clinics in Southampton, Bristol or Oxford. The service coordinated these appointments.
- All referrals to the learning disability team were allocated within two weeks but some referrals for occupational therapy were waiting over 18 weeks. This was due to a new sensory assessment that had been started and become in great demand due to its effectiveness. This assessment was particularly useful for adults within the autistic spectrum. There was a target of completing continuing healthcare assessments within 28 days but we were told this was difficult to complete the required assessments and liaison within this time. We heard that from December 2015 a new "intensive support at home" would be starting and it was anticipated this would improve the referral to treatment times for the service.
- We saw evidence of teams meeting regularly to assess workload and waiting times. Data provided throughout the different locations showed how patients were able to access care in a timely way and within targets identified within the patient safety thermometer.

Learning from complaints and concerns

- We saw examples from within the Integrated Teams demonstrating learning from complaints.

Good

Are services responsive to people's needs?

- We saw information on how to make a complaint was included within information packs given to patients.
- 100% of complaints in the Integrated Teams from August 2014-2015 were of low to medium concern and were closed within the set time frame of 25 working days.
- We asked three patients we spoke with if they were aware of how to make a complaint and responded that they had been given this information at some point previously.
- Staff told us that working as an Integrated Teams meant that any learning from complaints could be disseminated across the team and changes to practice made more rapidly.
- Integrated teams worked closely with GP practices and regularly attended practice meetings where they were able to discuss complaints.

Good

Are services well-led?

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

Summary

We rated the well led domain as good and found there were some examples of very good practice.

We found that all managers and clinical staff were well informed about the strategy for community services. Staff were able to explain about the values and objectives, such as working closely with primary care services, providing a holistic service, promoting healthy lives and working in an integrated team of professionals.

There was a governance framework in place which gave clear guidelines over lines of responsibility. There were clear processes in place to monitor quality and risk and deliver an improving service. We found that there were some outstanding examples of auditing and action planning against identified shortfalls or areas for improvement by the different Integrated Teams and specialist county wide services.

The leadership and culture reflected the vision and values of the trust and encouraged staff engagement with delivering quality community based services. We found examples of outstanding leadership being provided by heads of locality and the clinical leads for this specialist services.

There was a culture of teamwork that permeated through the community adults service. Staff told us how in regular team meetings, information was disseminated from the board and how information which was feedback to the board was acted upon. Staff commented that they thought the community services were being, "invested in," and were positive about the direction the service was taking. Staff told us they felt included in the improvements and changes and valued by the organisation.

The provider had a lone working policy in place and staff safety was promoted. Safe lone working was implemented in different ways in the community.

There were examples of services taking action to promote improvement and best practice and to improve the service delivered to the community. We saw examples of innovative ideas being put into action.

Detailed findings

Service vision and strategy

- We found that all managers and clinical staff were well informed about the strategy for community services. Staff were able to explain the values and objectives, such as working closely with primary care services, providing a holistic service, promoting healthy lives and working in an integrated team of professionals. One manager described the service as, "care closer to home and with clinicians making decisions." Staff were also well informed about the need to work closely with clinicians working in other trusts in the county, as the majority of patient care pathways involved receiving treatment or attending a hospital run by the other two trusts in the county.
- The executive team had made a commitment to spend at least an hour a week visiting different teams. Since July 2015 eight visits had taken place by four executive team members. The provider aimed for this to provide a platform to discuss priorities and issues, celebrate successes, share ideas and learning. These took place during team meetings or handovers where possible. The provider published a schedule of visits on the intranet and staff could request a visit.
- All the managers and many of the staff we spoke with had met the director for community services and we were told that information about changes and potential future developments was well communicated and explained. Two managers expressed a view that the vision for the integrated teams was more clearly presented than the future development of the county wide specialist services. However, apart from these comments we found that all staff were overwhelmingly positive about the development of community services, the model of provision and service that was being promoted and the leadership that was being provided for this strategy.
- The director of community services had visited the diabetes service with human resources and a head of locality. This was to ensure discussion was ongoing with

planned changes following the head of diabetes retirement. Staff within the diabetes service said they were well informed about the future plans and developments.

Governance, risk management and quality measurement

- We found that there was a clear governance framework which gave clear guidelines over lines of responsibility. There were clear processes in place to monitor quality and risk and deliver an improving service. We found that there were some outstanding examples of auditing and action planning against identified shortfalls or areas for improvement.
- A Divisional Quality and Governance Facilitator rolewas created in April 2015. The role had links with the patient safety and quality group as well as the harm free care focus group.
- The trust had processes in place to systematically seek and provide assurance across the range of community services. The provider created a governance database in May 2015 to monitor safety, quality and harm free care. It provided an easy to access database with information under the headings of safe, effective, caring, responsive and well-led. Staff told us all team leaders had access and staff were encouraged to look at it. We found that not all grades of staff were familiar with this database at the time of inspection. Some staff accessed this data and used the information to discuss in team meetings. This database provided a clear point of access to information and contained planned actions and outcomes. Staff told us the impact of this was increased awareness of key safety data and increased local ownership of quality.
- The provider used the governance database to plan training and to mitigate risk to the service and its staff. For example, the community team recruited a number of new healthcare professionals with little experience of working in the community. As a result, appropriate training was tailored to this group to support them with community specific skills development, such as lone working, care continuity planning, patient records documentation and mental capacity training.
- There were excellent comprehensive auditing and performance measures in place that were reported on and from which action plans were developed and reviewed. We saw examples of locality action plans which covered a range of issues and were divided into the domains of safe, effective, caring responsive and well led. We saw evidence that these actions plans were peer reviewed and feedback was provided to the staff in the relevant locality. There were also risk ratings of red, amber and green on the various actions and issues that had been highlighted. The tissue viability service had completed a community wound and dressing audit report in June 2015. This audit established for example, the number and types of dressings in use and their effectiveness. Other audits seen included a report on the hydrotherapy service run by the physiotherapy outpatient department at the Salisbury hospital and also patient satisfaction audits on back, hip and knee classes run by the physiotherapy department. We also saw audits undertaken around end of life care, a clinical effectiveness audit for nurses, a community ward audit and annual had hygiene audits.
- The wheelchair service had completed an audit against the new national Wheelchair Charter documents “right chair, right time right now”. We saw action plans against on the identified shortfalls with clear timescales and objectives.
- Risk registers were in operation at both organisational and divisional level. Staff in the Integrated Teams were familiar with the risk that was highest on the community risk register. This related to the risk of patients being admitted to hospital as a result or having their transfer home delayed due to the capacity and capability of ‘help to live at home’ care providers. Local risk registers were also in place. For example the wheelchair service had a risk register that had identified the IT change as a risk and also the private patients’ transport service that was sometimes late in collecting patients after they had been to the centre for an assessment.
- The community nursing teams, in conjunction with the tissue viability nurses, had a Commissioning for Quality and Innovation (CQUIN) target in place for the reduction of all grades of pressure ulcers. All grades of pressure ulcers were documented on the provider’s computer incident reporting system, and those that were assessed as a grade three or four were investigated. Learning from

the investigation was shared with the community staff. The provider achieved an 85% compliance with the pressure ulcer CQUIN target during the months of June to September 2015.

- The majority of senior staff were able to describe the organisation's governance arrangements. Risks were discussed at team leader level and submitted to the patient safety and quality meetings. If it was agreed that the item raised was a risk, an action plan was initiated or the item added to the risk register. All risks above 12 were reviewed at the patient safety and quality meeting on a monthly basis or at the patient safety committee if they scored 15 and above. Senior leaders told us the risk mitigation process had become increasingly robust over the last twelve months.
- Staff told us they attended weekly, bi-monthly and monthly team meetings. These included monthly, Integrated Teams meetings and weekly or bi-monthly therapy team meetings. Minutes of some of these meetings were available and showed the issues discussed and actions taken. Others were less formalised.
- Integrated team leaders used a number of tools to gather data needed to meet the organisation's governance arrangements. Incidents, accidents and near misses were recorded and investigated using the provider's electronic recording system. All staff we spoke with were aware of the system and were using it effectively.
- One of the deputy heads of locality told us about the template review group which they were involved in. This was reviewing all the forms that were to be used on the new electronic system to help with the process of ensuring they were fit for purpose.
- The continence team had bi-monthly team meetings where feedback was provide from various team members who had a responsibility for certain areas of work. For example feedback was provided on audits of the continence pathway and on the implementation of new NICE guidelines.

Leadership of this service

- The leadership and culture reflected the vision and values of the trust and encouraged staff engagement with delivering quality community based services. We found examples of outstanding leadership being provided by heads of locality, team leaders and the clinical leads for specialist services.
- Staff we spoke with all said they were provided with clear leadership, both within their individual teams and also at a trust level in terms of the developments in community services. All the clinical leads we spoke with were positive about the quality of leadership they were provided with. Several staff commented that there was empathetic and compassionate management.
- Staff were well supported by management and there was a culture of openness, honesty and learning. Staff told us team leaders within the Integrated Teamss operated an open door policy. Staff said they felt listened to by managers and were also aware of the management structure between themselves and the board. Staff were clear about the lines of accountability.
- We saw how time was set aside on a regular basis for Integrated Teams meetings. Some staff attended team meetings in different localities in order to share learning between locations. We heard of an example of how this had changed practice and made improvements to ensure patient records were stored confidentiality.
- Senior staff told us they encouraged away days and team development time. We saw an example of how one community team had used this time to develop its team mantra and for learning and development.
- The provider had created a communication, education and development role eighteen months ago. This role had a specific focus on the community. The provider audited community staff's skill-mix at the outset of this role and this was assessed against the needs of primary care and general practice. As a result, an extensive training programme was established. Integrated Teams redistributed work to the most appropriate community role. This resulted in a better use of staff's time, skills and resource. Staff told us they were able to visit patients at a time to suit their needs. For example, a patients no-longer needed to wait around for a nurse, if an assistant practitioner had been trained to carry out a specific procedure, such as venepuncture.

Culture within this service

Good

Are services well-led?

- There was a culture of teamwork that permeated through the community adults service. Staff told us how in regular team meetings, information was disseminated from the board and how information which was feedback to the board was acted upon. Several staff commented that they thought the community services were being "invested in" and they were positive about the direction the service was taking. Staff also told us they felt included in the improvements and changes and valued by the organisation.
- Staff told us how team leaders within the Integrated Teamss operated an open door policy. This meant that the team felt supported by management and it facilitated a culture of openness, honesty and learning.
- We saw how time was set aside on a regular basis for Integrated Teams meetings. Some staff were able to attend these meetings in different localities in order to share learning between locations.
- Staff talked openly about how they felt it was a positive environment to work in and we saw that staff were well motivated to provide quality community services. We were told how training was prioritised and time off to complete training or to attend clinical updates outside of the trust was permitted in order to maintain and enhance clinical skills.
- The provider had a lone working policy in place and staff safety was promoted. Safe lone working was implemented in different ways in the community. For example, in one team, we saw how staff had marked themselves in and out of the building and a rota was displayed on the wall in order to cross reference where staff were due to be on duty. A visits diary enabled teams to track any scheduled visits, and staff would only see patients on their way in or way home from work if they were familiar to them. One member of a team told us how they had experienced being "chased" by colleagues to ascertain their whereabouts, as they had forgotten to phone in and sign out. We heard consistently that teams were effective at calling each other, how visits diaries were used to track staff and how next of kin could be contacted if necessary.

Public engagement

- Patients were invited to complete comment cards and also compete the friends and family when accessing the community services.
- A questionnaire was sent out to patients who used the Pulmonary Advice and Community Exercise service (PACE). This is an exercise service for patients with long term lung conditions, particularly Chronic Obstructive Pulmonary disease. As a result, clinic times were re-scheduled to start mid-morning and to finish in the early of the afternoon. Staff also ensured the PACE service was run in a place where patients had access to the building on flat ground, with close car parking.
- There was no recognised patient forum to support service development, however there are examples of patient involvement in developing improved services through Healthwatch and local Area Board Forums and specialist services involve patient groups where appropriate, e.g. Breathe Easy and MND services

Staff engagement

- Staff we spoke said they felt fully engaged with the trust. Staff told us the changes over the past 18 months had contributed to a greater feeling of connection with the acute trust, which for some staff was located a good distance away.
- Staff said they were kept well informed by the trust through their managers and through the weekly emails sent from board.

Innovation, improvement and sustainability

- There were examples of services taking action to promote improvement and best practice and to improve the service delivered to the community. We saw examples of outstanding and innovative ideas being put into action.
- We spoke with a physiotherapist whose role was to provide clinical leadership to nurse clinical leads in the community for people who had been diagnosed with motor neurone disease and other specialist neurological conditions. They provided help with assessment and access to specialist care. This included considering patients and carers spiritual and religious needs and linking this with end of life care needs, as well as the physical assessment. We saw evidence of this supporting patients to remain in their own homes for longer and having less need to attend clinics for consultations.
- Physiotherapy were also increasing the role of extended scope practitioners, which are band 8 physiotherapist

who have undertaken additional competencies. There was a pilot scheme in place which enabled some GP referrals to be triaged by an extended scope practitioner and then be referred directly for their operation. This saved the patients an additional visit to the hospital for a meeting with the consultant and decreased the waiting time for the required operation. The pilot was being run in conjunction with consultants from a hospital run by another trust. If successful there were plans to extend the service across the county. This new clinical pathway would mean that a some patients needing a total knee or hip replacement could be directly listed for their operation without the need for an interim hospital visit.

- The learning disability service were organising a learning disability awareness week. This was taking place in the main acute hospital site. Staff would be engaging with other clinicians and members of the public to raise awareness of the services that were provided from the team throughout the acute trust and the community.
- The learning disability service worked closely with social care professionals employed by the local authority. There was service level agreement that provided a senior manager from the local authority who managed the community team in conjunction with one of the locality heads. The community learning disability team were due to start using a joint recording electronic system with the local authority from January 2015. This will ensure that social care and health professionals share information. This is intended to further improve the integrated working between the two organisations.