

Head Quarters (HQ)

Quality Report

Newholme Hospital
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information we hold about quality, and information given to us from patients, the public and other organisations.

Overall rating for this service

Community services for children and families	
Community services for adults with long-term conditions	
End-of-life care	
Other services	

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	3
The five questions we ask and what we found at this location	5
What we found about each of the core services provided from this location	6
What people who use the community health services say	9
Areas for improvement	9
Good practice	9

Detailed findings from this inspection

Our inspection team	10
Background to Head Quarters (HQ)	10
Why we carried out this inspection	10
How we carried out this inspection	11
Findings by main service	12

Summary of findings

Overall summary

Derbyshire Community Health Services NHS Trust Head Quarters (HQ) is based at Newholme Hospital in Bakewell, Derbyshire. It was first registered with CQC on 31 March 2011 to provide the regulated activities: Diagnostic and screening procedures, Family planning, Nursing care, Surgical procedures, and Treatment of disease, disorder or injury.

The Trust delivers a variety of community services from its Head Quarters across Derbyshire and in parts of Leicestershire, including community nursing and therapies, urgent care, rehabilitation, care of people with a learning disability, services for children and families, end of life care, podiatry, dental services, outpatients and day case surgery.

Head Quarters (HQ) was inspected by the CQC in 2013. We found the provider was not meeting the essential standard, respecting and involving people in their care. At this inspection in 2014, we found the provider was now meeting this standard. We inspected Buxton Hospital minor injury unit twice in 2013. At the last inspection in July 2013 we found the provider was not meeting the essential standard, supporting workers. At this inspection in 2014, we found the provider was now meeting this essential standard, and the findings of the inspection are reported here under minor injury units.

We inspected the following core services:

- Community services for children and families
- Community services for adults with long-term conditions
- End-of-life Care

We also inspected:

- Learning disability services
- Minor injury units
- Dental services
- Elective care services

Patients were overwhelmingly positive about the care and treatment they received. Patients were routinely viewed as partners in their care and decision making was personalised to meet their short and long term needs.

However, in some services care plans were not always sufficiently detailed and there were not always the right risk assessments in place to promote people's welfare and safety.

Patients and their families were treated with compassion and respect, and were involved in their care and well informed. There was a focus on promoting independence and self-management.

Care and treatment was safe because there were systems for identifying, investigating and learning from untoward incidents. Staff had received training in safeguarding vulnerable adults and were confident about reporting their concerns. There were systems in place to ensure the safety of staff working alone in the community, but these were not consistent across the Trust.

Care and treatment were evidence based and followed recognised and approved care pathways. In many areas we found integrated pathways of care that were working very well, and care was centred on the patient. There were good information sharing systems, so that people received joined up care from different professionals, although this did not work so well with providers across county boundaries.

Staffing levels were generally suitable but arrangements were not always sufficient to ensure that staff had manageable caseloads and that patients could access therapy services when they needed to. The Trust responded to changing local priorities and addressed the demands on services. In several areas there were weekend, evening and early morning clinics or educational courses, to improve access for patients. There were long waiting times for certain dental treatments and access to some outpatient or specialist therapists.

Discharge planning from community hospitals was effective with regular multidisciplinary discharge meetings that were used positively and involved all relevant health and social care staff.

Summary of findings

There were organisational governance and risk management structures in place. Staff felt included in the Trust's vision and felt supported to raise concerns. There was open and supportive leadership at all management levels throughout the Trust.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

Care and treatment was safe because there were systems for identifying, investigating and learning from untoward incidents. Staff had received training in safeguarding vulnerable adults and children and were confident about reporting their concerns. There were systems in place to keep staff working alone in the community safe, but these were not consistent across the Trust.

Are services effective?

There was a focus on promoting independence and self-management. Care and treatment were evidence based and followed recognised and approved care pathways. However, in some services care plans were not always sufficiently detailed and there were not always the right risk assessments in place to promote people's welfare and safety.

In many areas there were integrated care pathways that were working very well, and care was centred on the patient. There were good information sharing systems, so that people received joined up care from different professionals, although this did not work so well with providers across county boundaries.

Staffing levels were generally suitable but arrangements were not always sufficient to ensure that staff had manageable caseloads and that patients could access therapy services when they needed to.

Are services caring?

Patients were overwhelmingly positive about the care and treatment they received. Patients were routinely viewed as partners in their care and decision making was personalised to meet their short and long-term needs. Patients and their families were treated with compassion and respect. Patients and their families were involved in their care and well informed.

Are services responsive to people's needs?

The Trust responded to changing local priorities and addressed the demands on services. In several areas there were weekend, evening and early morning clinics or educational courses, to improve access for patients. However, there were long waiting times for certain dental treatments and access to some outpatient or specialist therapists.

Discharge planning from community hospitals was effective with regular multidisciplinary discharge meetings that were used positively and involved all relevant health and social care staff.

Are services well-led?

There were organisational governance and risk management structures in place. Staff felt included in the Trust's vision and felt supported to raise concerns. There was open and supportive leadership at all management levels throughout the Trust.

Summary of findings

What we found about each of the core services provided from this location

Community services for children and families

Care provided to children, young people and families was safe because there were systems for identifying, investigating and learning from safety incidents. Staff were well trained in safeguarding and protecting children from abuse and confident of their own roles and responsibilities. However, not all staff had received training in domestic abuse. Staff received regular safeguarding clinical supervision to support them in the care they provided to children at risk of abuse. They worked in collaboration with other services and disciplines to safeguard children and young people.

Care was effective, focussed on people's needs, evidence based and followed approved national guidance and nationally recognised assessment tools. There was effective information sharing between midwifery, health visiting and school nursing services which ensured the smooth transition of children from one service to another. However, there appeared not to be consistent communication from trusts in neighbouring counties, informing health visitors of forthcoming births.

People were involved in and central to making decisions about the care and support they needed. Staff provided compassionate and empathetic care; people had positive experiences of care and felt fully supported by children's community services.

Staff responded to people's needs promptly and provided dedicated care to vulnerable groups such as travelling families. The Trust used social media to meet the communication needs of young people and parents and to increase access to the health visiting service. However, there had been no consultation with people regarding the planned reduction in the number of well baby clinics.

There were organisational, governance and risk management structures in place. Staff told us there was two way communication between staff and managers. Staff felt included in the organisation's vision and supported to raise concerns.

Community services for adults with long-term conditions

Patients receiving care and treatment for long term conditions were overwhelmingly positive about the care they received from dedicated, compassionate staff. Especially at home, patients were routinely viewed as partners in their care and decision making was personalised to meet their short and long term needs.

Overall there were effective and reliable systems in place to enable staff to deliver safe care. Staff completed suitable risk assessments and appropriate screening tools. However, support for staff working alone in the community was not consistent.

Care and treatment were evidence based and followed recognised and approved care pathways. In many areas we found integrated pathways of care that were working very well, and care was centred on the patient. Specialist nurses and therapists worked with a degree of autonomy in the community, while able to access advice from or make referrals to other professionals easily.

Professionals in community teams worked well together. Staffing levels were generally suitable but staff did not always have manageable caseloads and waiting lists for some therapy services were very long due to reduced staff numbers.

The Trust responded to changing local priorities and addressed the demands on services. In several areas there were weekend, evening and early morning clinics or educational courses, to improve access for patients who were working. Discharge planning from community hospitals was effective with regular multidisciplinary discharge meetings that were used positively and involved all relevant health and social care staff.

Summary of findings

Managers reinforced the Trust's vision and values. They showed strong management skills, enabled regular staff training, group clinical supervision, and personal and professional support.

End-of-life care

Patients receiving end of life care were protected from abuse and avoidable harm by the systems, processes and practices in place. Staff had received training in safeguarding vulnerable adults and were confident about reporting their concerns.

Care provided to patients was effective and focussed on their needs. Care was evidence based and followed national guidance. There was effective collaboration between staff providing end of life care, including staff from other organisations.

Patients receiving end of life care were treated with dignity and respect by staff delivering the service. The majority of patients were satisfied with the service provided. Most patients and their families felt involved in discussions about care. However, we found that patients or their representatives were not always fully involved in discussions about 'Do Not Resuscitate' decisions.

Patients received care and treatment to meet their needs, including timely provision of medicines and equipment, and had access to end of life care services through several routes.

There were organisational, governance and risk management structures in place. Staff told us there was effective communication between staff and managers. Staff felt included in the organisation's vision and supported to raise concerns.

Other services

Learning Disability Services

Respite services for people with a learning disability were flexible and responsive to people's needs. Staff knew people well and treated them with dignity and respect, although care plans were not always sufficiently detailed. Overall people received good care. There were effective systems in place to manage referrals and assess people so that they were able to access a service that provided them and their families with appropriate support.

There were systems in place to record, analyse and learn from incidents. A range of standard risk assessments were in place and updated regularly. There were not always risk assessments in place to assess, manage and minimise known risks to people.

The service was well led. There was open and supportive leadership at all management levels throughout the organisation. There were prevailing worries from staff and people using the service about the future of the respite units, which was causing anxiety.

Minor Injury Units

Systems were in place to handle any identify, record and escalate any significant incidents. Staff used the systems effectively and received feedback on the analysis of incidents.

There were suitable systems in place to ensure staff were trained in recognising abuse of adults and children. There were reporting systems and interagency procedures in place which staff used if they had concerns. The services provided effective treatment to patients within acceptable waiting times. There were systems and relationships with other agencies established which meant on-going care arrangements were made to meet patient's needs.

Summary of findings

Patients received good care from staff who regarded them with dignity and respect. Patients were kept informed about waiting times and given explanations regarding their care. Staff provided care and emotional support to patients in clean and calm environments. Staff received on-going training, supervision and annual appraisals to ensure they were suitably skilled for their role.

The minor injuries units were responsive to the needs of patients and were highly valued by local communities. Staff had developed an innovative information booklet for children. The involvement of staff did not end when the patient left the minor injury unit and there were systems in place for staff to arrange aftercare for patients.

The service was well led at all levels in the organisation. Staff were well supported by managers and were involved in the plans for the development of the minor injury services.

Dental Services

Patients received good dental care and treatment which was provided in a timely way. There were systems in place to keep patients safe. Staff treated patients with respect and dignity.

Dental services were generally responsive to patient's needs and wishes. Clinic appointments could be made easily and quickly. There were long waiting times for treatments which needed to be done under full sedation.

Staff were trained and supported to carry out their role. Dental service improvements were made in response to patient feedback and a robust audit framework. The dental services were well-led. Leadership and communication at all levels were open, supportive and inclusive.

Elective Care

Generally services were safe and risks associated with the poor maintenance of the premises and some outdated equipment were being managed. Staffing levels on all the units we visited were safe. Staff moved between units and departments to ensure sufficient numbers of staff and minimise the likelihood of cancellation of lists. New measures had been put in place to prevent further breaches of patients' confidential personal information.

Patients were very happy with the care delivered at the units we visited and appreciated being able to attend a location close to home. Care and treatment was effective although there were few clinical audits to monitor outcomes and drive improvements. Care was personalised and patients were treated with dignity and respect. There were limited facilities for refreshments for patients and visitors. The Trust responded to patients' feedback and complaint.

Staff were supported through regular appraisal and access to training. Staff told us the Trust and local services were well-led and they felt informed about forthcoming changes. There was an open reporting culture; staff were encouraged to raise and report issues, although not all staff felt they received satisfactory feedback when they did.

Summary of findings

What people who use the community health services say

The Friends and Family Test seeks to find out whether people would recommend their care to friends and family. Derbyshire Community Health Services NHS Trust completed the test in April 2013. The most recent figures (October 2013) placed the trust in the top 25% of the whole of England. The overall performance was relatively stable with high performance scores close to the maximum of 100.

Overwhelmingly people we spoke with and received feedback from were positive about the care and treatment they received. They valued the services and told us staff often “went the extra mile.”

Areas for improvement

Action the community health service **SHOULD** take to improve

- All relevant health visiting staff should receive training in domestic violence.
- Equipment with an expiry date should be retained in the original packaging to ensure it is possible to check it is safe to use.
- Staffing levels should be reviewed to ensure specialist practitioners are able to provide an effective service without excessive waiting times for patients.
- Ensure senior clinicians follow the Trust’s policy on “Do Not Attempt Cardio-Pulmonary Resuscitation” (DNACPR) Decisions, by involving patients in the decisions, recording the discussions, and reviewing the decisions on a regular basis.
- Ensure that all staff teams have formal arrangements to ensure their safety when working alone in the community.

- Review the provision of dental treatment requiring full sedation to reduce excessive waiting times for patients.
- Ensure clinical and records audits are used consistently across the community services to monitor quality and drive improvements.

Action the community health service **COULD** take to improve

- Improve communication with trusts in neighbouring counties, so that health visitors are consistently informed of forthcoming births.
- Ensure that care plans and risk assessments for people with a learning disability are sufficiently detailed to promote their welfare and safety.
- Review staff training in the Mental Capacity Act so that all relevant staff receive this training.

Good practice

Our inspection team highlighted the following areas of good practice:

- There was effective multi-disciplinary working which provided very good integrated care.
- Patients and their relatives were involved in and central to making decisions about the care and support they needed.

- Staff were committed to providing high quality, compassionate care.
- Access to health visiting services was supported by the use of social media
- Staff had developed a children’s booklet ‘Teddy visits the minor injury unit’ to help younger children understand some of the treatments they may need.

Head Quarters (HQ)

Detailed findings

Services we looked at:

Community services for children and families; Community services for adults with long-term conditions; End-of-life care; Learning disability services; Minor injury units; Dental services; Elective care services

Our inspection team

Our inspection team was led by:

Chair: Helen Mackenzie, Director of Nursing and Governance, Berkshire Healthcare Foundation Trust

Head of Inspection: Ros Johnson, Care Quality Commission

The team included 11 CQC inspectors and managers, an analyst, 14 clinical specialists comprising community nurses, health visitors, a mental health nurse, acute care nurses, an occupational therapist, dentists, a GP and a Mental Health Act Commissioner, and 12 experts by experience who have personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to Head Quarters (HQ)

Derbyshire Community Health Services NHS Trust Head Quarters (HQ) is based at Newholme Hospital in Bakewell, Derbyshire. It was first registered with CQC on 31 March 2011 to provide the regulated activities: Diagnostic and screening procedures, Family planning, Nursing care, Surgical procedures, and Treatment of disease, disorder or injury.

The Trust delivers a variety of community services from its Head Quarters to approximately 1.1 million people across Derbyshire and in parts of Leicestershire, with more than 1.5 million contacts each year. Its services include community nursing and therapies, urgent care, rehabilitation, care of people with a learning disability, services for children and families, end of life care, podiatry, sexual health, health psychology, dental services, outpatients and day case surgery.

In Derbyshire its services are delivered across six localities: Amber Valley, Erewash, Chesterfield, Derbyshire Dales, High Peak, North East Derbyshire and South Derbyshire. In Leicestershire and Rutland the services are delivered at nine hospitals and 15 dental clinics.

Head Quarters (HQ) has been inspected once since registration, and was found non-compliant with Regulation 17, Respecting and involving people. Buxton Hospital minor injury unit was inspected twice in 2013, and at the last inspection in July 2013 was found non-compliant with Regulation 23, Supporting workers.

Why we carried out this inspection

Head Quarters (HQ) was inspected as part of the first pilot phase of the new inspection process we are introducing for

Detailed findings

community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Community services for people receiving end-of-life care.

During this inspection the team also looked at:

1. Learning disability services
2. Minor injury units
3. Dental services
4. Elective care services

Before visiting, we reviewed a range of information we hold about the community health services and asked other organisations to share what they knew about the provider. We circulated an electronic survey to community and voluntary organisations in the area of the trust. We held a focus group in which representatives of patient and service user groups shared views and experiences of the service. We also sent comment cards to be distributed around trust locations.

We carried out announced visits between 25 and 27 February 2014 to 35 locations from where the Trust delivers services. We went on home visits with four community teams of nurses and therapists. We held eight focus groups with a range of staff including community matrons, health visitors and end of life facilitators. We observed how people were being cared for and talked with carers and/or family members and reviewed patients' treatment records. We spoke by 'phone with more than 20 people who were receiving care at home, and reviewed 37 completed comment cards. We carried out unannounced visits on 7 March 2014.

Community services for children and families

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Community services for children and families include health visiting, school nursing, specialist children's diabetes, dietetics, speech and language therapy, physiotherapy, sexual health, safeguarding and looked after children.

The inspection team included CQC inspectors, specialist health visitors, registered children's nurses and experts by experience. During our inspection we spoke with staff and families. We visited health centres and children's centres; we observed clinics and telephoned and visited people receiving services at home. We also used information provided by the organisation and information that we requested, which included feedback from families using the service about their experiences.

Summary of findings

Care provided to children, young people and families was safe because there were systems for identifying, investigating and learning from safety incidents. Staff were well trained in safeguarding and protecting children from abuse and confident of their own roles and responsibilities. However, not all staff had received training in domestic abuse. Staff received regular safeguarding clinical supervision to support them in the care they provided to children at risk of abuse. They worked in collaboration with other services and disciplines to safeguard children and young people.

Care provided to children, young people and families was effective and focussed on their needs. Care was evidence based and followed approved national guidance and nationally recognised assessment tools. There was effective information sharing between midwifery, health visiting and school nursing services which ensured the smooth transition of children from one service to another. However, there appeared not to be consistent communication from trusts in neighbouring counties, informing health visitors of forthcoming births.

Children, young people and families were involved in and central to making decisions about the care and support they needed. People had positive experiences of care and felt fully supported by children's community services. Staff provided compassionate and empathetic care.

Staff responded to the needs of children, young people and their families promptly and provided dedicated care to vulnerable groups such as travelling families. The Trust used the social media to meet the

Community services for children and families

communication needs of young people and parents and to increase access to the health visiting service. However, there had been no consultation with people regarding the planned reduction in the number of well baby clinics.

There were organisational, governance and risk management structures in place. Staff told us there was two way communications between staff and managers. Staff felt included in the organisation's vision and supported to raise concerns.

Are community services for children and families safe?

(for example, treatment is effective)

Safety in the past

Children and young people were protected from abuse and avoidable harm. We spoke with health visitors and school nurses who demonstrated a good knowledge of the importance of reporting incidents. There were systems in place for staff to record any concerns or incidents regarding domestic abuse and we saw evidence that staff had been made aware of the need to report incidents of domestic abuse as a significant event within the Trust.

Staff told us that they had received training in safeguarding children and vulnerable adults at a level appropriate to their role. Staff we spoke with demonstrated a good knowledge of what they would do if they had any safeguarding concerns regarding a child or vulnerable adult. Safeguarding policies were available for staff to refer to and staff knew where to locate them for support.

Some staff told us they had received domestic abuse training and others had not. The 'East Midlands Regional Standard Operating Procedures for the Healthy Child Programme Universal Contacts' outlines specific contacts and timings when health visitors should consider discussing issues around domestic abuse with people who use the service. When we spoke with staff we found that not all health visitors were aware of these timings. This meant that the opportunity for a person to disclose issues about domestic abuse may have been missed.

Learning and improvement

There was an electronic reporting system through which staff reported incidents and staff told us they received feedback about what they had reported. Learning from these incidents was shared with staff at team meetings and was reflected in the training staff received.

There was evidence that learning had taken place following serious case reviews. One member of staff told us, "Learning from serious case reviews is shared with the school nurses via a letter, training, supervisions, team meetings and the Trust intranet". Lead safeguarding nurses were well known by staff and staff told us they could easily access the safeguarding leads if they needed advice or support. Staff told us that they received three to four

Community services for children and families

monthly safeguarding clinical supervision with a safeguarding nurse which they used to reflect and learn from cases they had worked on. One member of staff told us, “I have three monthly safeguarding clinical supervision which is excellent”.

Systems, processes and practices

The majority of staff told us their managers were supportive and they felt comfortable to discuss any issues. An electronic records system ensured records of children were available across multiple locations. This enabled effective multi-disciplinary working and timely information sharing. It meant staff could highlight risks within families such as child protection concerns and ensured a greater sharing of information between the health visiting and school nursing services when a child moved from one service to another. Staff told us that in addition to this, face to face handovers took place between health visitors and school nurses for children with additional needs.

There were systems in place to ensure electronic equipment, such as weighing scales, were maintained and calibrated to ensure they were fit for purpose. Staff were aware of current infection prevention and control guidelines and we observed good infection prevention and control practices, such as:

- alcohol hand gel available for staff to take into the community
- staff following recognised hand hygiene techniques
- clearly defined roles and responsibilities for cleaning equipment used in people's homes and clinics

Staff told us there were infection control champions linked with the infection control team to act as a resource to other members of staff.

Monitoring safety and responding to risk

There was appropriate staff skill mix in teams, and comprehensive training supported safe practice. For example, breastfeeding support workers worked alongside health visiting teams to support mothers. Systems were in place to promote the safety of staff when lone working and staff we spoke with were aware of where to locate the lone working policy to refer to for support. Staff told us they kept electronic diaries so other staff members knew where they were visiting. They informed a colleague where they would be visiting and were provided with mobile phones. Where

required they carried out joint visits and had received conflict resolution training to help them to identify and manage risks to themselves. As a result, staff felt safe and secure when working alone in the community.

Most staff we spoke with told us there were processes in place to respond to the fluctuating demands of their caseloads. However two health visiting teams told us they had not been supported when there was an increase in child protection activity or another member of staff was off with a long term illness.

Anticipation and planning

The Trust has made good progress in delivering the Department of Health's Health Visiting Implementation Plan. Recognised best practice tools had been introduced such as The Ages and Stages questionnaire to assess the development of a child and the Healthy Child Programme was embedded into health visiting and school nursing practice. Ante-natal visits were provided for expectant mothers at approximately 28 weeks of pregnancy so that any risks to themselves or their unborn baby can be addressed in a timely manner. Additional support was put in place where required. Additional health visitors had been trained and recruited to help to meet the demands of the service. Most staff that we spoke with told us there were enough staff to meet the needs of the people who used the service.

Are community services for children and families effective?

Evidence-based guidance

We observed that care was evidence based and followed recognised and approved national guidance such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. These included the Ages and Stages questionnaire to assess a child's development and Whooley questions and the Edinburgh Post Natal Depression Scale to assess for post natal depression.

Staff were clear of roles in care pathways and worked well with multi-disciplinary colleagues to ensure optimum health and wellbeing of children and families. Staff told us they worked collaboratively with the children's centre

Community services for children and families

workers, schools, GPs and drug rehabilitation teams. For example, one health visitor told us that multi-agency forums were held on a regular basis for all professionals interested in supporting breastfeeding mothers.

There was a system in place within the electronic records for staff to identify and record who had parental responsibility for a child. This meant that the appropriate people were asked for consent when care and treatment was delivered to a child. School nurses followed Gillick competency guidelines in determining a child's ability to provide consent to care and treatment. A Gillick competent child is a child under 16 years of age who has the legal capacity to consent to care and treatment.

The Royal College of Paediatricians' guidelines regarding the frequency that babies need to be weighed, led to a reduction in the number of well-baby clinics throughout Derbyshire. The Trust told us that there had been engagement with people and staff during 2010 - 2011 about this. All the people and staff we spoke with told us they had not been consulted about this action. However, staff we spoke with told us they had been given assurances by their managers that the closure of the clinics would be closely monitored to ensure that children and their families continued to receive a service that met their needs.

Monitoring and improvement of outcomes

One team of health visitors told us that by monitoring the activity within a well-baby clinic they identified issues around infection control. By changing the layout of the clinic, mothers were supported to wash their hands after changing their baby's nappy. This meant that the potential spread of infection was reduced.

Area health profiles identified health indicators for Derbyshire which were significantly worse than the English average. One of these indicators was the number of mothers who started to breast feed their baby. The Trust was not meeting its Commissioning for Quality & Innovation (CQUIN) target for mothers sustaining breastfeeding from 10 days to six weeks. This is monitored through the Trust's risk register which demonstrated that there had been a 6% increase between November and December 2013. Breastfeeding support workers had been employed to encourage and support mothers to start breast feeding. People who used this service spoke positively about the support they had received. One person told us, "I would have given up breastfeeding if it wasn't for X (the breastfeeding support worker)".

Staffing arrangements

Health visiting caseload sizes were determined by the use of January 2012 populations and the Child Wellbeing Index 2010. However we saw no evidence of how this was used to reflect the changing practices brought about by the Health Visiting Implementation Plan. Most schools nurses told us there were adequate staffing levels and skill mix. Generally staff were positive about recruitment practices and told us that the induction was helpful to new starters. Mandatory training and study days facilitated up to date evidence based practice and staff felt the content of mandatory training was appropriate. All the staff we spoke with had received an annual appraisal of their performance and received regular safeguarding clinical supervision. However, there was no formal process in place for staff to receive regular practice clinical supervision.

Clinical practice was monitored by record keeping audits with common themes fed back to staff via monthly operational meetings, clinical supervision and peer reflection. We spoke with a student health visitor who told us they received 'long armed' mentoring from a health visiting community practice teacher but also had a mentor within the team to provide daily support and guidance. The student health visitor told us that they felt confident to approach their mentors for support.

At the end of November 2013, 80% of staff had received an appraisal in the previous year. The Trust had set a target of 100% staff receiving an appraisal. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. All the staff we spoke with within children's community services told us they had received an appraisal within the last 12 months. Staff told us they were supported to access and attend mandatory training to ensure they had the appropriate skills and training to make effective clinical decisions and provide care in a prompt and timely manner.

Multidisciplinary working and support

There was good collaborative working between all members of the multidisciplinary team across children's services to promote best outcomes for children and their families. We observed staff working well together in clinic settings and found that healthcare professionals valued and respected each other's contributions in the planning and delivery of care. Parents told us they were clear about who to go to for support and how to contact them. Staff

Community services for children and families

told us that they had developed good links with GPs, speech and language therapists, children's centres, schools and the drug rehabilitation team. This meant that care with other services was well co-ordinated.

Co-ordination with other providers

There were systems in place for the smooth transition of children and their families from midwifery to health visiting services and from health visiting to school nursing services. However, when a pregnant woman received 'consultant only' ante-natal care or ante-natal care from a neighbouring Trust there appeared not to be consistent communication informing health visitors of these forthcoming births. This meant that some pregnant women had not received an ante-natal visit from the health visitor resulting in their and their babies' needs not being assessed in a timely manner.

Collaboration with partner agencies was generally effective. Multi-agency staff worked together at clinics and in groups; communication systems were effective. For example, when a child with complex needs moved from one school to another we saw that the child's plan of care ensured that staff at the new school were supported and educated by school nurses to ensure they had sufficient knowledge to care for the child whilst they were in school.

Effective care delivered close to home

Care was planned to ensure that children and young people received a service that met their needs, was delivered as close to home as possible and minimised disruption to the family. This included local clinics, joint appointments and home visits. There was evidence of cross team working between therapists, school nurses and health visitors. One speech and language therapist told us that due to the high non-attendance rates of children and young people they now visited children and their families in their own homes or at their school to ensure children received the appropriate care.

Children and their families told us they received effective care and the measures taken by staff ensured care was delivered close to or in their homes.

Are community services for children and families caring?

Involvement in care

Children, young people and families were involved in and central to making decisions about the care and support they needed. One person told us, "It completely met our needs. You can get informal support". People who used the service told us they were also provided with literature to read to ensure they were able to make informed choices about their care. Another person who used the service told us they were supported in the decisions about stopping breastfeeding. They told us, "Support on the transition from breast to bottle was very good".

People spoke positively about having choices and influence over the care that they or their child received. Parents and children were involved in discussions about the planning of care for children with complex health needs or where a child protection plan was in place. Meetings were held between families and staff to ensure that a child's care needs were met.

Staff had a good understanding of consent and applied their knowledge when delivering care. There was a system in place within the electronic care records for staff to identify and record who had parental responsibility for a child. This ensured that the appropriate people were asked for consent when care and treatment was delivered to a child.

Trust and respect

Staff treated children, young people and their families respectfully, developing trusting relationships. For example, we observed positive interactions between staff and a parent. A person using the service told us, "I'm never been made to feel stupid, as though I'm asking stupid questions. I know I can always contact them. It's just brilliant".

People told us sensitive and emotive subjects were discussed in privacy to maintain their confidentiality. For example, when mothers were assessed for postnatal depression they told us they were offered the option of this being carried out at home or in a private room at the clinic. There was a private one-to-one room in a clinic we visited and people who used the service confirmed that this was used.

Community services for children and families

Patient understanding of their care and treatment

Health visiting and school nursing staff regularly adapted their style and approach to support children and families to understand and be involved in their care and treatment. For example, staff had access to a translation service for non-English speaking people. Staff used the Ages and Stages questionnaire to involve parents in the assessment of their child's development and provided feedback and advice regarding their progress.

People told us they knew who their named health visitor was and they were able to contact them if they had any concerns or issues they wanted to discuss about care and treatment. Parents and carers were provided with information and explanations, where appropriate, which was supported by the use of leaflets and literature. One person told us, "The support I've had has been absolutely brilliant. I wouldn't have got through the last three months without them".

The Trust had a health visiting website and Facebook page to support children, young people and their families. They provided information on health promotion and advice about issues such as feeding, sleeping and the management of minor illnesses in children. Downloadable leaflets were available on the website for people to print off if they needed. Staff encouraged people to access this site by promoting it during contacts and providing leaflets about how to access it.

Emotional support

Staff were clear on the importance of emotional support people needed. The 'East Midlands Regional Standard Operating Procedures for the Healthy Child Programme Universal Contacts' outlines specific contacts and timings based on NICE guidelines when health visitors should assess mothers for post-natal depression. Staff accessed these guidelines on the Trust intranet. The outcome of the assessments for post-natal depression were recorded in the person's electronic record. When additional emotional support was needed it was provided by either the health visitor or other appropriate services the health visitor referred into. School nurses worked with schools ensuring that appropriate plans of care were in place to meet children's emotional needs when they attended school.

Health visitors provided ante-natal home visits which helped staff identify the additional support a family might

need after the baby's birth. One person told us, "The ante-natal visit was helpful. It was good to chat to the health visitor as my first birth was stressful. It definitely allayed my fears".

Compassion, dignity and empathy

Staff provided compassionate care, based on the individual needs of children, young people and their families. Children were treated with dignity at all times and family members considered staff to be sensitive to their individual needs. We observed staff during nine home visits. We saw that staff were respectful when entering people's homes. We observed a health visitor providing additional time whilst a person using the service discussed personal issues.

In January 2014 the Trust carried out an audit of breast feeding support which involved issues around privacy and dignity. We saw that all the feedback was positive and recommendations were made where needed.

Are community services for children and families responsive to people's needs? (for example, to feedback?)

Meeting people's needs

Health visitors and school nurses met the needs of children, young people and their families. Communication was reviewed to ensure that staff working with children received timely and accurate information. For example, we saw that audits of children's electronic care records identified problems with some of the referral letters used by health visitors. In response to this, letter templates had been amended.

Staff met the needs of children, young people and their families in a timely manner. For example, care pathways meant that school nurses responded immediately to a young person's request for emergency contraception. They not only responded quickly to this request but provided responsive sexual health promotion advice to educate the young person to help to prevent future unwanted pregnancies or sexually transmitted diseases.

Most school nurses and health visitors told us there were systems in place to share safeguarding cases equally in teams. This meant that children at risk of harm were protected because the Trust had a system in place to ensure staffing capacity met the needs of people.

Community services for children and families

Access to services

Services for children and their families were accessible at a place convenient for them. Staff working with children and their families provided care within various settings. These included children's centres, clinics, schools and in people's own homes. People told us there were no problems accessing services and that they could always speak with a member of staff when they needed to. One person told us, "My wife needed to speak to the health visitor and within half an hour they had received a phone call back". Individual needs in relation to culture, belief and values were respected.

A speech and language therapist told us that due to high non-attendance rates they now delivered their service to children and young people in their own homes or at their school to ensure services were accessed. Generally access to services to ensure children and young people received the care they required was good. However health visitors were not always informed of forthcoming births if women received 'consultant only' ante-natal care or ante-natal care from a neighbouring trust. This meant that pregnant women did not always gain access to health visiting ante-natal visits because lines of communication between the Trust and other providers were not effective in meeting their needs.

Health visitors and school nurses told us they received specific training to reflect the needs of the communities they served. There were systems in place to support staff to deliver services to hard to reach groups such as travelling families.

In response to requests from young mothers and the changes in the way young people communicate, the Trust had established a health visiting website and Facebook page to promote access to the health visiting service. Leaflets to promote the usage of this service were available.

Leaving hospital

There were systems in place for staff working in local minor injury units (MIU) and accident and emergency (A&E) departments to share information about children and young people's attendance with the health visiting and school nursing services. This enabled staff to identify any additional support a child may require when returning home. Staff told us that in some neighbouring hospitals there was a paediatric liaison sister who rang the community children's services if there was urgent information of concern. There was a system in place for

school nurses to review all attendance letters from MIUs and A&Es. If a child attended more than three times in 12 months the reasons for attendance were reviewed and staff responded to any identified risks.

Support in the community

Staff told us there was a good working relationship between health visitors and school nurses. Some staff attended multi-disciplinary meetings at GP practices where they discussed the care of children with specific needs or children who had recently been discharged from hospital. There was evidence of good collaborative working between children's community services, children's centres, GPs, midwives and in some areas, the drug rehabilitation team. The manager of one children's centre told us, "Communication with the health visitors is getting better all the time. We do good face to face contacts to discuss what's good about the support we offer to children and what isn't".

When a child was identified as having additional needs, staff used the common assessment framework (CAF) to bring together professionals from the relevant services to co-ordinate appropriate community support. Staff delivered the Healthy Child Programme visiting children and their families in a variety of locations so they were easily accessible. Health visitors delivered ante-natal visits in people's homes to promote understanding of the care and treatment they could receive.

Learning from experiences, concerns and complaints

Complaints to the Trust decreased between 2012 and 2013. Most complaints were in relation to aspects of clinical treatment. Staff told us there was a system in place for people to complain and learning from these complaints was shared with health visitors and school nurses. We received consistently positive comments on the children and young people's services from the people who used the service. Families reported feeling listened to and heard. One person told us, "I would recommend the service to my friends and family".

There was no evidence of consultation with people who used the service regarding the planned reduction of the well-baby clinics within the Trust. Some staff we spoke with expressed concerns about people's ability to access clinics,

Community services for children and families

but most people said they would still be able to access a clinic in their area once a week. One member of staff told us, “I think it is worth a try but it needs to be audited quickly to check that it works”.

Where concerns were raised, we heard examples of learning and practice developments. For example, staff told us managers had listened to their concerns about the reduction in the number of well-baby clinics and had been given reassurances that it would be reviewed in May 2014.

Are community services for children and families well-led?

Vision and governance framework

Staff were clear about the organisation’s vision, ‘To be the best provider of local healthcare and to be a great place to work’ and the organisation’s values. Staff referred to this as ‘working the DCHS way’. The corporate induction for new staff included the provider’s core values and objectives for the organisation. Staff told us that the Board and senior managers were visible and approachable. There was a culture of open communication, encouraging staff and families to express concerns. Staff received a weekly e-mail from the Chief Executive informing them of developments within the trust and staff achievements. There was also a Trust newsletter called ‘The Voice’ that kept staff up to date with relevant trust information.

Senior staff were clear about priorities for their services in line with the Joint Strategic Needs Assessment and Public Health priorities including the initiation of breast feeding and the reduction of smoking in pregnancy. We saw examples of partnership working to improve care outcomes for children and young people. For example, breast feeding support workers working alongside health visitors to increase breast feeding rates and schools working closely with school nurses to address the issue of unwanted pregnancies.

Promoting innovation and learning

Staff working in children’s services understood and were aware of best practice initiatives and key performance indicators and considered the organisation supportive of new initiatives. School nurses gave examples of changes in the way they addressed sexual health issues with young people. The changes within the health visiting service brought about by the Health Visiting Implementation Plan, such as the introduction of ante-natal visits and the use of

motivational interviewing, were becoming embedded into practice. The development of a card outlining the changes in the health visiting service and key contact times was inserted into children’s personal child-held records to ensure that parents were fully informed of the changes taking place. There were innovative practices such as communicating with young people and families by the use of social media.

Further examples of staff led innovation were evident in the speech and language therapists’ approach to taking their service to children and young people to ensure service access. Examples of learning from external reviews meant that during 2012 the Trust commissioned a review of children’s services delivered through Minor Injury Units.

Leadership development

The majority of staff said there was visible leadership across the organisation and expressed confidence that any concerns raised with managers would be acted on. Staff were aware of who the Trust board members were and spoke positively of changes that had taken place within the organisation since the appointment of the current Trust board. We saw notice boards on display in several clinics informing staff of who the Trust board members were.

Staff told us that their managers were visible, accessible and approachable and that opportunities to lead in key areas were available. For example, we spoke with one health visitor who was a champion for leading on and promoting the initiation and sustaining of breast feeding. There were information leaflets for families encouraging feedback on their healthcare experience and cards for the Friends and Family Test were given to people at each contact they had with community children’s services. The Friends and Family Test seeks to find out whether people would recommend their care to friends and family.

Staff engagement

The majority of staff told us they felt communication was good within the Trust, for example meetings, newsletters, weekly e-mails from the Chief Executive and briefing documents. Staff told us that the Chief Executive of the Trust actively encouraged staff to respond to her weekly e-mails and that she in return would reply. There was also a discussion board for staff on the intranet.

Staff told us they were made aware of when new policies were issued and that they could locate them for reference

Community services for children and families

on the Trust's intranet. They felt included in the organisation's vision. Most staff were very positive about working for the Trust and told us they felt valued and supported.

Community services for adults with long-term conditions

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Derbyshire Community Health Service NHS Trust Head Quarters (HQ) delivers care and treatment to adults with long term conditions through a number of community and hospital based services, in partnership with Derbyshire Adult Social Services and other statutory and voluntary agencies.

Community matrons identify, assess and manage the care of complex patients with long term conditions. Community nurses also manage people with long-term conditions, and often work in integrated teams alongside physiotherapists and occupational therapists. There are a large number of specialist teams and services including the stroke co-ordination service, the specialist continence nursing advice, treatment and education service, community cardiac rehabilitation, the community diabetes specialist nursing team, specialist nurses in certain conditions such as Parkinson's Disease and Motor Neurone Disease, education programmes for people with diabetes and other long term conditions, tissue viability nursing, community heart failure and respiratory services and rehabilitation teams, and the intermediate care service.

During our inspection we visited these teams at community hospitals, health clinics and community centres across Derbyshire. We spoke with approximately 60 people receiving treatment and more than 30 staff including community matrons, therapists, podiatrists, nurses, senior managers and health care assistants; we also reviewed information from comment cards completed by people using the services.

Summary of findings

Patients receiving care and treatment for long terms conditions were overwhelmingly positive about the care they received from dedicated, compassionate staff. Especially at home, patients were routinely viewed as partners in their care and decision making was personalised to meet their short and long term needs.

Overall there were effective and reliable systems in place to enable staff to deliver safe care. Staff completed suitable risk assessments and appropriate screening tools. However, support for staff working alone in the community was not consistent.

Care and treatment were evidence based and followed recognised and approved care pathways. In many areas we found integrated pathways of care that were working very well, and care was centred on the patient. Specialist nurses and therapists worked with a degree of autonomy in the community, while able to access advice from or make referrals to other professionals easily.

Professionals in community teams worked well together. Staffing levels were generally suitable but staff did not always have manageable caseloads and waiting lists for some therapy services were very long due to reduced staff numbers.

The Trust responded to changing local priorities and addressed the demands on services. In several areas there were weekend, evening and early morning clinics or educational courses, to improve access for patients who were working. Discharge planning from community hospitals was effective with regular multidisciplinary discharge meetings that were used positively and involved all relevant health and social care staff.

Community services for adults with long-term conditions

Managers reinforced the Trust's vision and values. They showed strong management skills, enabled regular staff training, group clinical supervision, and personal and professional support.

Are community services for adults with long-term conditions safe?

Safety in the past

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The four harms that it measures frequently affect people with long term conditions, such as pressure ulcers or falls. The Trust had processes in place for reporting harms and monitoring their extent in different service areas, including in people's homes. Regular reports were available through the patient safety group; the trust's 'learning the lessons group' helped focus and drive improvement and ensure learning was trust-wide. We saw clear action plans in response to serious incidents, which were tracked and updated regularly.

Safety incidents were reported, investigated and lessons learned as a result. Staff described ways in which they reported incidents such as pressure ulcers, or misplaced patient information, and how they received feedback so as to inform practice. A small number of staff said they did not get the feedback they needed. Staff were clear about the criteria for reporting safety incidents. Staff working in the community told us the documentation for reporting pressure ulcers had been streamlined, which had helped the process. We saw evidence that root cause analyses (RCA) were carried out and that learning was taking place as a result, such as improved recording of communication with care home staff. In one area we saw that common themes were collated for sharing across localities, and better staff guidance had been developed in the form of an easy reference laminated sheet.

Derbyshire Adult Social Services has developed local safeguarding thresholds to be used by all agencies. Staff were aware of these and the trust's safeguarding policies and procedures. However, we found that actions taken to safeguard individuals were not always documented as they should be.

Learning and improvement

The electronic incident reporting system supported people to learn from incidents and near misses. We found robust root cause analyses were completed, with the support of specialist staff, and this led to useful action plans and shared learning. A number of staff told us managers and team leaders discussed incidents and the learning from

Community services for adults with long-term conditions

these incidents at monthly meetings, bringing this back to their teams for dissemination. We looked at six sets of notes from integrated community managers and matrons meetings held from September 2013 to February 2014, but did not see any record of such discussions. However from talking with staff we found that learning was taking place and changes to practice were being implemented. These included improved identification of pressure ulcer grades and ensuring people's care was regularly reviewed by the appropriate professional.

In December 2013, a Pressure Ulcer Workshop was run by senior quality staff for Integrated Community Team managers and leaders to agree structure and process. Further RCA training was arranged for January 2014. We saw a locality Pressure Ulcer Prevention Action Plan, dated 1 February 2014. This showed a clear response to the themes identified during RCAs of pressure ulcer incidents. Actions were identified at individual, team, directorate and organisation level with start and completion dates, resources required and evidence needed for completion. This was scheduled for discussion at a forthcoming staff meeting. The team leader told us they intended to share this action plan with other localities.

Systems, processes and practices

Overall there were effective and reliable systems in place to enable staff to deliver safe care. Staff completed suitable risk assessments and appropriate screening tools. Patients and staff told us that pressure areas on their skin were checked routinely where indicated, so as to help prevent pressure ulcers. Professionals in community teams worked well together and referred patients on when other professional input was required. Community nursing documentation centred on safety, and we observed comprehensive patient records that were clear and accurate. Staff knew how to report safeguarding concerns and told us they received regular safeguarding training

The national NHS Staff survey results for 2013 show a positive incident reporting culture at the Trust. Staff were supported to report incidents and raise concerns without fear of negative consequences. Staff showed us examples of completed electronic incident forms and described the feedback from managers. They were actively encouraged to report incidents, and shared learning in staff meetings. Minutes of staff meetings confirmed this.

Care and treatment was provided safely in community premises and in people's own homes. Staff adhered to

infection prevention and control practices and there were effective systems in place to dispose of clinical waste and sharps. People's medicines were reviewed regularly and were managed safely. A monthly clinical quality and patient safety report was completed by the Trust. Within this report insulin administration was identified as an area of concern across inpatient services. Since April 2013 there had been 16 incidents regarding the administration of insulin. A root cause analysis was conducted by the Insulin Review Group and changes put in place to prevent incidents occurring to other patients. Staff told us that all insulin is now checked by two members of staff before it is administered and they had been provided with e-learning training on the administration of insulin. Most staff said they had completed this training.

We found some examples of poor record keeping relating to safety. In one district nursing team patient records were not stored securely, as a key has been lost, and no action had been taken to replace it. Records were electronic or paper based, depending on the location of the service. Current paper notes were kept in the person's home so that they were available for staff at each visit. In general there was a move to transfer to electronic recording and initially this was time consuming for staff. Staff had contributed to developing user-friendly templates. Teams found remote internet connections were variable, and sometimes made lone working in remote areas difficult. In cases where GP records were held on another system, staff made contact with the practice to receive the key information they needed. They did not report this as a significant barrier to providing care and felt the contact with GP surgeries worked well.

Monitoring safety and responding to risk

The Trust had some arrangements in place to identify and manage risks in delivering care and treatment in the community. The Lone Worker Policy (December 2011) was under review at the time of the inspection. Staff were aware of the policy but did not report completing the checklist or profile as set out in it. The Trust sent us a copy of the policy and this did not include the lone worker profile document or procedures for line managers to follow should their staff fail to report in for duty.

In some teams, appointments were held on an electronic calendar, which all staff could access. Staff told us they used their mobile phones to keep in contact, particularly when working late. In general staff told us they felt safe and

Community services for adults with long-term conditions

doubled up when a risk was identified. District nurses told us at weekends they buddied with another team, so as to make sure everyone was safe, but we did not find this was a formalised system. Some staff did not feel safe at weekends because of reduced staffing levels. A small number of staff had used an 'intelligent badge' which provides electronic tracking as they go on home visits.

Community nursing staff told us they carried out holistic assessments that covered all aspects of health and social care needs. They could request equipment such as grab rails. This meant that patients were kept safe at home by addressing all possible risks rather than different professionals looking at one area at a time.

Staff told us they felt comfortable escalating issues and concerns to their managers and that managers usually dealt with or escalated issues appropriately. Staff received feedback in staff meetings, on the intranet and on staff information boards. Overall there were effective systems in place to cascade learning through the organisation, although in some areas, staff told us that their concerns were not properly escalated and/or they did not get satisfactory feedback.

Anticipation and planning

Specialist nursing staff told us how they were involved in root cause analyses, supporting staff and teams in understanding the contributory factors better and in learning from incidents. They told us updates on certain issues were made available on the Trust's intranet. Clinical practice facilitators were also active in supporting people in their roles and helping them to improve practice in response to learning from incidents. Staff felt standards had improved as a result of this input.

Are community services for adults with long-term conditions effective?
(for example, treatment is effective)

Evidence-based guidance

The care and treatment provided was evidence based and followed recognised and approved care pathways. These included early supported stroke discharge, managing type 2 diabetes, Dose Adjustment For Normal Eating to manage type 1 diabetes, motor neurone disease, chronic obstructive pulmonary disease and the Expert Patients Programme for people living with a long-term condition. In

the community we observed thorough assessments, competent wound care and good medicines management. We observed staff following recognised guidance and good practice in respiratory nursing. Patients told us staff always explained what they were doing and asked for consent before commencing any treatments.

In many areas we found integrated pathways of care that were working very well. Staff and patients told us communication with different professionals was effective, and care was centred on the patient. Patients and their relatives were proactively encouraged to be involved in their care; they felt listened to and were involved in decision making at all levels. One community nursing team told us how they now used a more wide-ranging and holistic approach to care planning. This incorporated practical support the patient needed and any risks to compliance with the care plan.

Specialist nurses and therapists worked with a degree of autonomy, while able to access advice from or make referrals to other professionals easily. We observed a respiratory nurse practitioner during a home visit. Following observations, they rang the patient's GP during the visit, agreed a different approach to medication and went through a steroid reducing programme with the patient, discussing the effects, possible side effects, and what to do in case of certain symptoms.

Monitoring and improvement of outcomes

Teams and departments gathered feedback from patients and used recognised health indicators to measure improvements. The Expert Patients Programme for people with long term conditions is a national educational and support programme run by trained tutors who are all living with long term conditions themselves. They were assessed for competency before delivering the programme and receive regular peer review and supervision. Staff told us they aimed for and achieved 80% improvement in quality of life measures over the six week course, and then these were monitored again following six months. Feedback from patients was overwhelmingly positive.

We also heard and read very positive feedback from patients attending diabetes education courses. We observed a half-day session. Patients attended the first session with their medical results, so that these could be

Community services for adults with long-term conditions

used to develop personalised plans and set individual goals. Part of the session concerned the potential benefits and side effects of different medicines for diabetes, so that people could make informed choices.

As part of monitoring outcomes for people, there was a monthly audit of care records. Community team managers told us they gathered feedback from patients so as to capture their experience and make improvements to the service, but it was not done consistently. Community nurses handed out comment cards to patients, based on the national 'friends and family test' They told us they were supposed to hand them out at every contact but felt this was too frequent. Staff had recently started to phone people discharged from hospital and those receiving care at home to gather feedback.

We received feedback from a large number of people receiving different Trust services for people with long term conditions. Without exception they were glowing in praise for the positive impact on their lives.

Sufficient capacity

In January 2014 an internal audit report on workforce planning identified the need to strengthen strategic planning, refresh guidance for managers, review the workforce planning documentation, and improve reporting criteria and the clarity of management information. The Trust had a workload and dependency tool for community nursing teams, but it was not used consistently, and it did not enable resources to be moved to areas of greater need. In January 2014 the Trust established a project group with CCG representation and expert advice to carry out a diagnostic review of current activity and patient acuity within community nursing teams.

There was also work ongoing to map the therapy resources within each locality and reconfigure staffing in terms of in and out reach within community and acute hospitals. This also supported the seven day working agenda. In December 2013 a sub group of the Workforce Group (which reports to the Quality People Committee) was tasked with providing assurance that Allied Health Professionals were properly managed by the Trust and contributed optimally to clinical delivery, including through learning needs analysis and workforce plans. Notes from an Allied Health Professionals network meeting in November 2013 identified actions relating to support workers' competencies, learning needs, clinical supervision and in service training.

Many staff told us staffing levels were suitable and they felt well supported by their managers. A community nurse said, "We are all very clear about how we plan and manage our caseloads. Everything we do is risk assessed and we all work together, share information and put the patient first." Another told us how caseloads were managed by offering telephone support and explaining the parameters of care available to patients; they also focused on self-management through one-to-one sessions so as to decrease the number of follow up visits. Community teams in North Derbyshire used the caseload weighting tool in order to manage and allocate work. They employed agency staff to cover long term absence and staff training, and worked with other teams to support each other. In Chesterfield the rapid response nursing service enabled patients, often with acute exacerbations associated with long term conditions, to receive treatment at home instead of going into hospital. This was very well staffed with highly qualified nurses working to cover a small caseload. In Diabetic outpatient clinics we found staffing levels allowed for personal attention to patients who needed it; staffing levels were flexible to accommodate patient flow and some clinics were held on Saturdays.

Arrangements were not consistent throughout the Trust to ensure that staff had manageable caseloads. Some staff groups expressed concern at staffing levels and constantly having to manage large caseloads. Some specialist nurses felt overwhelmed by huge caseloads and working in isolation. In a neurological therapy outpatients department staff told us the waiting list was up to 16 weeks due to staff shortages. They felt patients were suffering as a result of this, and deteriorating unnecessarily. Others in the community expressed concerns at staffing levels at the weekend but told us they had been listened to and the shortfalls were being addressed.

Multidisciplinary working and support

We found effective communication and decision making about patients' care across all services delivering that care. Different professionals within the Trust worked well together and there was very good engagement and evidence of good working relationships with other health and social care providers in order to manage and meet people's needs.

In Long Eaton the integrated community teams had built up good relationships with local care homes, providing refresher training and advice. They were supported by a

Community services for adults with long-term conditions

care homes advisory service. This is a multi-disciplinary service providing specialist support in the care of older people already living in care homes, and signposting to other services such as the wheelchair services, dietician, speech and language therapy or falls team. Overall there was a commitment to early identification of problems and resolving them swiftly. In Swadlincote we found the single point of access (SPA) team highly commended by GPs. This integrated team triages urgent referrals to avoid unnecessary hospital admissions and enable patients to access the most suitable service. Integrated team members told us how they worked well as a single team with standard assessments and good clinical supervision. Community nurses told us how well supported they were by the tissue viability team.

Patients receiving care and treatment for diabetes, heart failure, pressure ulcers and respiratory conditions told us the staff communicated well with their GP and other professionals. They gave examples of how community staff had referred them to other services or support and advice groups, or had arranged other professionals to carry out assessment visits. The discharge management system worked well at Babington Hospital, with weekly meetings with social care, ensuring people's care was delivered at or as close to their home as possible.

Are community services for adults with long-term conditions caring?

Compassion, dignity and empathy

We received overwhelmingly positive feedback from patients on the compassion and empathy of staff. One person said, "I love my nurses they are super." Another told us, "They are gentle, kind and caring. Their manner is lovely." People told us they felt treated with respect and staff didn't rush them. We observed positive interactions between staff and patients in a number of different care settings. Staff spoke with people respectfully, explained things well, checked the patient's understanding and didn't make assumptions. Staff used positive non-verbal communication too, to establish rapport with patients. More than one patient commented it was clear the staff member liked their job and that it was "more than just a job" to them.

Involvement in care

Patients were routinely viewed as partners in their care and decision making was personalised to meet their short and long term needs. Patients and their relatives felt listened to and involved in decision making at all levels. Patients told us everything was explained to them very well, and they could ask questions when they needed to. One person told us, "I definitely feel involved in my care; they explain everything and ask me lots of questions; they are kind and respectful. They take things step by step and are receptive to my needs."

We observed some home visits and saw holistic care, with patients fully involved in their care plan. Community nurses frequently spent time with patients explaining about medication and its potential benefits and side effects; they supported people in making informed decisions about their treatment. We saw that community staff proactively sought resources and support for people in formats other than written English. Interpreters were available and we saw that a range of services including Polish, Czech and British Sign Language had been used. We did not always see easy read leaflets available but staff told us the health promotion team could supply them.

People we visited at home were familiar with their care plans and told us they were involved in it, including where staff used electronic records and brought a laptop with them. Community teams told us that if they considered people did not have capacity to consent to their care, they did a referral for a mental capacity assessment, but they were unable to show us evidence of this. Staff liaised with social services in the care of people with a learning disability, to ensure they were able to access any relevant support services.

Educational programmes for people with long term conditions were held in accessible buildings and provided information and learning materials in a range of formats. People attending these sessions told us they felt very involved, able to share their experiences, express their views and make suggestions. The approach was workshop based, rather than classroom learning, so there were opportunities for group discussion and problem solving. One person said, "It's been very informative; I feel confident to face it head on." People felt they received a personalised support package, as well as benefitting from being part of a peer group for mutual support. We found that information

Community services for adults with long-term conditions

was not always provided at a suitable level of detail or signposted in a suitable way, but people's understanding was checked with quizzes and people were helped to set realistic goals.

Trust and respect

Patients' medical, emotional and social needs were identified and incorporated into care planning. We heard consistently positive views from patients and carers about being given choices and treated with respect. We observed staff working hard to understand people's points of view and searching out the right kinds of support. One person commented how her community nurse was very kind and didn't patronise or preach; others told us how nothing was too much trouble for staff.

Emotional support

Patients and carers were supported emotionally, and supported to manage their own health and maintain their independence. Patients told us the community nurses acknowledged the emotional impact of a long term condition and were very supportive. A patient with heart failure referred to the benefits they had received from the "emotional and welfare package of care." Another who had treatment in their own home told us how she looked forward to the nurses coming in; they were pleasant and cheerful, while maintaining a professional attitude. They said, "She's made my life better, she's an absolute diamond. I don't know what I'd have done without her"

Are community services for adults with long-term conditions responsive to people's needs?
(for example, to feedback?)

Meeting people's needs

We found the Trust responded to changing local priorities and addressed the demands on services. In several areas there were weekend, evening and early morning clinics or educational courses, to improve access for patients who were working. Some patients receiving community nursing visits at home told us staff would attend at a certain time if asked. Others said the nurse called them in advance to let them know they were on their way. We heard good feedback about telehealth equipment that supports people to monitor things like blood pressure and blood glucose levels at home. The results are automatically

transmitted to the doctor or nurse, who can review the information and phone the patient if there are concerns. This helped reduce the number of visits to the surgery or clinic and unplanned visits to the hospital.

The Trust employed a range of specialist teams to support staff in the community and on inpatient units. These included continence nurse specialists, falls teams and speech and language therapists. Patients were able to self-refer to many of these services. Other teams were established and in the process of developing such as the rapid response nursing team in Chesterfield and single point of access teams across Derbyshire.

The Trust was working with a local acute hospital to appoint community advanced nurse practitioners working on the acute re-ablement unit at the hospital to facilitate a smooth hand over of care between providers. The Trust was also involved in an outpatient antibiotic service enabling community based delivery of intravenous antibiotics administered by community nurses.

Some teams, in particular neurological and musculoskeletal physiotherapy outpatients, were struggling with long waiting lists and felt that patients were deteriorating because they could not access treatment and advice when they needed it. Patients were waiting for around 16 weeks for an appointment. They had looked at ways of managing caseloads by offering group classes and clinics. But they were concerned they were not offering a responsive service to people with long term conditions who had an exacerbation or relapse. One patient told us they had been off work for ten weeks before attending their first physiotherapy appointment. The service was not able to provide important maintenance for these patients.

Access to services

Most teams and clinics we visited provided effective access to appropriate services. Community teams worked in an integrated way so that patients received the services and support they needed. Staff told us everyone was familiar with different professional roles and were able to work effectively together. Patients told us they were very satisfied with the access to services. Some described how they were able to attend clinics or receive home visits according to their changing needs. We saw evidence of business cases being put forward to support the recruitment of additional staff to provide people with better access to services.

Community services for adults with long-term conditions

Although working as part of an integrated musculoskeletal pathway, there were long waiting lists for screening such as an MRI scan. The integrated pathway was for patients requiring consultant appointments for chronic joint problems. Patients had to wait to see different professionals so that it took about five months from referral to see a consultant. Audits showed that up to half of the patients needed surgical intervention.

Vulnerable patients and capacity

Staff felt they had sufficient safeguarding training for their role although only district nurse managers received Mental Capacity Act training. They received good support from the Trust's safeguarding leads and were able to liaise with social workers where needed.

Leaving hospital

We found good examples of discharge planning with the involvement of community and hospital based staff. Planning for the provision of community based care was in place before discharge. We observed some multidisciplinary discharge ('Jonah') meetings and saw they were used positively and involved all relevant health and social care staff. Patients' and carers' views were taken into account in the discharge plans. Staff told us that using the Jonah system had improved the patient flow and efficiency of services. Effective discharge was sometimes impeded by long waits for follow up outpatient physiotherapy.

Learning from experiences, concerns and complaints

The Trust was a key partner in the local health economy's development of seven day services and promoting the delivery of extended service provision across the week. The area was successful in its application to be one of 13 'Early Adopter' sites, and the formal launch was in January 2014. The Trust was developing an Advanced Nurse Practitioner role to work across both acute and community trusts supporting patients both in acute care and in the community, in and out of hours.

In response to the National 'Call to Action', promoting the need for more integrated care and to increase capacity within the community, and reflecting patient feedback, the Trust was taking part in local development driven by clinical commissioning groups. This included developing a

template of integrated care for each CCG area, focused on establishing Community Matron and Care Coordinator roles, Virtual Ward principles and enabling Multidisciplinary Teams to work in more integrated ways.

Are community services for adults with long-term conditions well-led?

Vision, strategy and risks

The Trust had a clear statement of vision and values in the 'DCHS Way' which embodies a quality service, people and business. This was visible on displays throughout the Trust buildings, and was apparent in many conversations with staff and observations of staff acting with compassion and respect, and seeking out new ways of working together for the benefit of patients. The DCHS way is underpinned by clear ambitions, principles and values.

Staff told us that the board and senior managers were visible and approachable and that they received a weekly e-mail from the Chief Executive informing them of developments within the trust and staff achievements. There was also a Trust newsletter called 'The Voice' that kept staff up to date with relevant trust information.

Senior staff were clear about priorities for their services in line with the Joint Strategic Needs Assessment and Public Health priorities. We saw examples of partnership working to improve care outcomes for people.

Quality, performance and problems

We found evidence that staff learning and personal development were encouraged. Most staff told us they had regular one-to-one meetings with their manager to review caseload and other issues. They could also request meetings with a clinical lead to work on problem solving or difficult cases. All the staff we spoke with told us they had an annual appraisal and most found it useful. Staff told us they had accessed and were up to date with relevant training. Some teams described peer review in addition to appraisals and clinical supervision. Therapy staff did not have consistent access to professional development, although this was being addressed by a recent senior appointment at director level in the Trust.

Community nurses told us they felt well supported and could call their manager at any time, including out of hours. New staff reported good wider support from the

Community services for adults with long-term conditions

team, with identified mentors and buddies. Staff told us how they had raised issues such as staffing levels which had been identified at a wider service level and additional staff were recruited as a result.

Leadership and culture

Staff described supportive leadership at all levels and that Board members regularly visited teams and departments. Some senior managers were reported as listening to staff and taking action on concerns raised, but this was not a consistent view across the Trust. Some managers were split between different hospitals or teams and this was disruptive for staff. We found that many managers were acting into the role and some had been for a long time.

In many areas, managers reinforced the Trust's vision and values. They showed strong management skills, enabled regular staff training, group clinical supervision, and personal and professional support. Staff told us there was an open culture within the Trust. Staff felt listened to and valued. The Chief Executive was well known and seen to be

open and supportive. One community nurse told us, "This is the happiest I have ever felt since working for this trust; we are fully supported" Another said, "They make us feel the job we're doing matters."

Patient experiences and staff involvement and engagement

Staff in many teams and hospitals felt involved in the Trust and well informed of organisational developments. Some staff told us how they had raised concerns and solutions had been put in place as a result. Some community teams felt isolated from the rest of the Trust and although they were developing their own innovative and supportive practices, there was a risk of missed opportunities for learning and sharing. Some part time staff felt it was difficult to make time for required training and did not feel supported with this.

Patients and people using services were contacted for feedback on their experiences of care and treatment. In most areas this information was used to review ways of delivering care and we found examples of changes as a result. We found that patients knew how to make a complaint and felt comfortable doing so.

End-of-life care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The Trust's end of life services are nurse-led and provided by community and in-patient nursing teams. There is no separate team specifically to deliver end of life care. There is a team of four end of life care development facilitators. Their role is to deliver training to staff from the Trust, care homes and GP surgeries, and to support and drive forward initiatives that sustain and develop quality end of life care across a range of care settings.

We looked at end of life care as delivered by staff working in the community and on the wards in community hospitals.

Summary of findings

Patients receiving end of life care were protected from abuse and avoidable harm by the systems, processes and practices in place. Staff had received training in safeguarding vulnerable adults and were confident about reporting their concerns.

Care provided to patients was effective and focussed on their needs. Care was evidence based and followed national guidance. There was effective collaboration between staff providing end of life care, including staff from other organisations.

Patients receiving end of life care were treated with dignity and respect by staff delivering the service. The majority of patients were satisfied with the service provided. Most patients and their families felt involved in discussions about care. However, we found that patients or their representatives were not always fully involved in discussions about 'Do Not Attempt Resuscitation' (DNACPR) decisions.

Patients received care and treatment to meet their needs, including timely provision of medicines and equipment. Patients had access to end of life care services through several routes.

There were organisational, governance and risk management structures in place. Staff told us there was effective communication between staff and managers. Staff felt included in the organisation's vision and supported to raise concerns.

End-of-life care

Are end-of-life care services safe?

Safety in the past

There were systems in place to monitor and report safety incidents. Staff were familiar with the reporting systems and told us they were encouraged to use the systems to report incidents. Qualified staff were trained to perform root cause analysis (RCA) and these were reported to managers in a timely manner. Staff had received training in safeguarding children and vulnerable adults.

The majority of serious incidents reported by the Trust were significant pressure ulcers. Most of these incidents occurred in patients' own homes. The rate of new pressure ulcers during the period December 2012 to December 2013 fluctuated with more periods where it rose above the England average. Patients at home and in community hospitals were assessed for their risk of developing pressure ulcers.

We found that the rate of reported venous thromboembolism (VTE) for the provider was below the England average for the period December 2012 to December 2013. This measures whether or not a patient is being clinically treated for a VTE of any type. The provider's policy was that all patients should be assessed on admission to hospital for their risk of developing VTE. We saw that VTE assessments had been completed in most of the patient records we looked at.

Learning and improvement

The end of life service was evaluated by the Trust in 2013 using questionnaires to patients and their families. The questionnaire asked if patients and families felt the overall care delivered was safe and if any medical crisis was addressed in a safe and effective way. The report of the evaluation showed that the majority of responses were positive. Action was taken to address issues raised and to improve the service. This included improving communication and coordination of care across different care settings.

A monthly clinical quality and patient safety report was completed by the Trust. Within this report insulin administration was identified as an area of concern across inpatient services. Since April 2013 there had been 16 incidents regarding the administration of insulin. A root cause analysis was conducted by the Insulin Review Group and changes put in place to prevent incidents occurring to

other patients. Staff told us that all insulin is now checked by two members of staff before it is administered and they had been provided with e-learning training on the administration of insulin. Most staff said they had completed this training.

Systems, processes and practices

There was a system in place to prioritise patients receiving end of life care at home. Patients were identified as red, amber or green. Green was for patients newly identified as needing end of life care, amber for patients with more symptoms, and red for patients in the final stages of their life. This system allowed community staff to prioritise their visits and workload.

Monitoring safety and responding to risk

Anticipatory medicines boxes, called 'Just in case' boxes, had been introduced in north Derbyshire for patients at home. Anticipatory medicines are those prescribed for use on an 'as required' basis to manage common symptoms that can occur at the end of life. The medicines typically include opiates which are likely to be controlled drugs, (drugs that are subject to strict legal controls to prevent them being misused, obtained illegally or causing harm). The end of life care development facilitators told us that the safe use of the boxes was being monitored by them and the community nurses. A survey was in progress looking at the safe and effective use of the boxes.

Anticipation and planning

The use of the Liverpool Care Pathway (LCP) in end of life care was to be phased out in line with recent guidance from the Department of Health. The LCP was a tool developed to help doctors and nurses to deliver quality end of life care. The LCP documentation allowed all care to be recorded in one place by any provider. The end of life care development facilitators were working on new documentation to replace the LCP. They wanted to ensure that the new documentation would be used by all care providers in a similar way to the LCP. This was to reduce the risk of breakdowns in communication between providers, particularly in an emergency as services would be reliant on the documentation kept in the patients' home.

End-of-life care

Are end-of-life care services effective? (for example, treatment is effective)

Evidence-based guidance

The end of life care development facilitators had developed the Derbyshire End of Life Quality Award (DELQA). This was based on the Gold Standards Framework (GSF), a systematic, evidence based approach developed to improve quality of care for patients considered to have a life expectancy of less than 12 months. Department of Health guidance is that all organisations providing end of life care are expected to adopt a co-ordinated process, such as the GSF. The end of life care development facilitators told us that DELQA was as robust as the GSF and had been well received. The award can be revoked if the provider does not maintain the appropriate standards.

Monitoring and improvement of outcomes

The 'Just in case' anticipatory medicines boxes meant that patients did not experience delays in receiving treatment, such as for pain relief or nausea. The end of life care development facilitators had launched the boxes through events attended by GPs and pharmacists. They found there was a better uptake in one area because the launch event was well advertised and promoted.

The use of the 'Just in case' boxes and advance care planning had reduced avoidable hospital admissions, allowing patients to stay at home if this was what they wanted. Advance care planning was promoted and used for people in their own homes or in care homes. The same system and documentation for advance care planning was in use throughout Derbyshire to ensure familiarity and consistency of care by all staff involved.

The end of life care development facilitators team promoted the role of end of life care champions and provided training and support for them. The champions were based in hospitals and the community and there were approximately 60 in total. The champions were staff who had put themselves forward for the role because of their interest, experience and commitment to end of life care. There were quarterly meetings for champions who then fed back information to their colleagues.

Sufficient capacity

The end of life care development facilitators team had caseloads based on GP practices. They said this worked well as the caseloads were manageable and they could

develop good working relationships. District nurses reported that patients having end of life care typically made up 50 to 60% of their caseloads, which could be challenging at times.

Multidisciplinary working and support

The end of life care development facilitators promoted integration and provided training for Trust staff, GPs, district and community nurses, healthcare support workers, and care home staff. They worked closely with local hospices and the Macmillan nursing team.

Staff working on inpatient wards told us they had received support and training from the end of life care development facilitators. Staff on one ward told us about a patient who had planned to use the local hospice for end of life care, but who unexpectedly needed urgent admission to the ward. Staff said the patient stayed on the ward to the end of their life, cared for by the ward staff and supported by Macmillan nurses, staff from the hospice and community staff.

Are end-of-life care services caring?

Compassion, dignity and empathy

Advance care planning was promoted by the Trust to support patients to have the care and treatment they wanted in the place they wanted to be at the end of their lives. The report of the evaluation of end of life services showed that nearly all the respondents said that care in the last days of life was in accordance with the wishes of patients and their families. The majority of respondents said that information was given to them in a sensitive way.

On some inpatient wards, patients at the end of life were placed in single rooms to allow greater privacy for them and their families. Staff on inpatient wards told us that relatives could visit at any time and stay as long as they wanted to if the patient was at the end of their life.

A report from the Southern Derbyshire Clinical Commissioning Group in October 2013 found that patients receiving end of life care in their homes were treated with dignity and respect by DCHS staff.

End-of-life care

Involvement in care

The use of advance care planning included the involvement of patients and their relatives or carers. The majority of respondents in the evaluation of end of life services said that patients and their families were involved in discussions about care.

Planning for end of life care included making a 'Do Not Attempt Resuscitation' (DNACPR) decision. We found that these decisions did not always follow the Trust's policy to have discussions with patients or their representatives and to note these discussions on the DNAR form. This meant that patients and their representatives were not always fully involved in discussing and making this important decision.

Emotional support

The majority of respondents in the evaluation of end of life services said that patients were emotionally supported and the needs of their families or carers were also considered. Most respondents felt they were emotionally supported following the patient's death.

The Trust provided information in leaflets and on their website for patients, their families and carers about the support available for people at the end of their lives. This includes how people can access emotional as well as practical support from the Trust and from other organisations.

Are end-of-life care conditions services responsive to people's needs?
(for example, to feedback?)

Meeting people's needs

One patient told us the care they were receiving "Has helped me to stay at home. The nurses are brilliant." More than 90% of respondents in the evaluation of end of life services said they were either satisfied or very satisfied with most aspects of the care provided.

Specialist equipment was available in the home for patients requiring palliative care, such as syringe drivers for use in managing pain relief. The majority of respondents in the evaluation of end of life services said the patient was provided with all the medicines and equipment they needed.

Access to services

Patients were referred to end of life services through hospitals, MacMillan nurses, GP, community nurses or by self-referral. GPs, district nurses and community staff usually carried out initial assessment of the patient's needs and wishes. Community matrons were also involved in supporting the patient and their family.

Information about end of life services was displayed on inpatient wards and was available on the Trust's website. The end of life care development facilitators were involved in raising public awareness through events as part of the Dying Matters Coalition. This Coalition aims to change public knowledge, attitudes and behaviours towards dying, death and bereavement.

Learning from experiences, concerns and complaints

The end of life care development facilitators were working on actions taken in response to the evaluation of end of life services. This included looking at issues such as patients' spiritual care needs and the promptness of response in a crisis.

Are end-of-life care services well-led?

Vision, strategy and risks

Information about the provider's vision and values was prominently displayed in the hospital. Most staff we spoke with were aware of the provider's approach to delivering quality services: 'The DCHS Way'.

Quality, performance and problems

The end of life care development facilitators met together regularly to reflect on their practice.

Leadership and culture

The end of life care development facilitators told us they had good support from each other and from managers. They were pleased that a senior manager had a key focus on end of life care. They said, "We can speak with senior managers, they're not in ivory towers. They've been very supportive of the end of life care champions." and, "They're receptive to our ideas. They're very keen on quality and end of life care and I find that refreshing."

End-of-life care

Patient experiences and staff involvement and engagement

Communication about changes in the Trust was cascaded to staff through several routes. The Trust issued a monthly bulletin, 'The Voice', and the Chief Executive wrote a weekly email to staff. Updates were discussed at team meetings

Learning, improvement, innovation and sustainability

The end of life care development facilitators had recognised that a replacement tool was needed for the Liverpool Care Pathway (LCP) as this was to be phased out. They had already started working on new documentation as they wanted this to be ready in plenty of time. They were involving staff, patients and families in developing the new tool.

Learning disability services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Learning Disability Services

Derbyshire Community Health Services NHS Trust provides four residential respite facilities for people with learning disabilities:

- Orchard Cottage situated in Darley Dale which accommodates up to five people
- Robertson Road in Buxton which accommodates up to five people.
- Rockley Core Unit in Shirebrook which accommodates up to five people in two bungalows.
- Amberley Core Unit at Eckington which accommodates up to six people.

The service offers flexible respite care families from between one night to three weeks. The respite services provide some nursing care provision but this is not on a 24 hour basis. The Trust also provides community based learning disability services to people living in their own home.

Summary of findings

Respite services for people with a learning disability were flexible and responsive to people's needs. Staff knew people well and treated them with dignity and respect, although care plans were not always sufficiently detailed. Overall people received good care. There were effective systems in place to manage referrals and assess people so that they were able to access a service that provided them and their families with appropriate support.

There were systems in place to record, analyse and learn from incidents. A range of standard risk assessments were in place and updated regularly. There were not always risk assessments in place to assess, manage and minimise known risks to people.

The service was well led. There was open and supportive leadership at all management levels throughout the organisation. There were prevailing worries from staff and people using the service about the future of the respite units, which was causing anxiety.

Learning disability services

Are learning disability services safe?

Safety in the past

There were systems in place to record any incidents or accidents. Staff were familiar with these processes and were able to describe examples where they had been used. Staff told us that any incidents which were reported were analysed and the findings were fed back to staff through team meetings to ensure there was learning through the organisation.

Learning and improvement

The Trust delivered safeguarding training to staff on an annual basis. The staff we spoke with confirmed that their safeguarding training was up to date. Staff were able to describe circumstances where safeguarding referrals had been made. We were given examples where multi agency meeting had been held to consider where allegations had been made. Staff could tell us who the named safeguarding lead was for the trust. All the families we spoke with felt the respite services were safe and that there was no risk of abuse to people who used the services. One person told us, "I feel so safe and looked after here".

Monitoring safety and responding to risk

Some standard risk assessments were routinely completed, including falls, moving and handling, tissue viability and nutrition. These were completed and updated regularly. However, the Trust did not have suitable systems for assessing and managing individual identified risks. We saw that in one respite unit staff were not following advice given by a healthcare professional to keep a person safe. The risk was known but there was no risk assessment or plan in place to describe how the person was to be kept as safe as possible.

At another respite service there was an identified risk evident, but the care plan was insufficient in describing the actions staff needed to take to keep the person safe. Whilst staff we spoke with were aware of how to manage the situation, the proper procedures were not recorded. We saw other risk management plans that were not sufficiently detailed to ensure a consistent approach by staff.

People took their own supplies of medicines into the respite units. Records of medication were not always accurate, but staff checked the current medications prescribed were accurate with relatives and GPs before writing the instruction on the administration record. In

general medicines were administered safely. We saw that most staff were trained in specific administration techniques such as buccal administration. This is an emergency technique where medications are rubbed into the gums, typically given during epileptic seizures. There were always staff on duty who were suitably trained. Most but not all medications were found to be stored suitably.

Systems, processes and practices

Patients' records were electronic and paper. We saw that there was suitable storage and security for records to ensure people's confidentiality. Staff told us that when there was a need to transport records they used lockable cases.

Whilst the Trust did have a lone working policy we found that staff were not aware of the content of the policy and procedure to be followed. This was relevant as we observed staff working alone with people. They told us they were unaware of the content of the lone working policy or how it applied to them.

The respite units did not have any dedicated domestic staff, so care staff were responsible for cleaning and maintaining standards of hygiene in the services. We saw that there were adequate supplies of personal protective equipment such as gloves and aprons for staff to use. We found variable standards of hygiene and cleanliness. Some respite units were clean but others had areas that were not clean, and we found inconsistent completion of cleaning schedules.

There was a system of audits and checks in place to ensure the environment was checked for health and safety hazards. We found that areas were mostly safe and suitable. However in one area we saw a fabric bath mat which was a potential slip/trip hazard. In another area there was an exposed set of pipes and an earth wire and sharp metal plate accessible to people behind one bath.

Are learning disability services effective? (for example, treatment is effective)

Care planning

Staff told us that care plans were not rewritten at each period of respite as people often the used the service on a regular base and there was frequently very little change between stays. Staff told us they checked the care plans to

Learning disability services

ensure they remained relevant. However there were no records or means of checking this had been done. This increased the risk of changes not being taken into account with staff not updating the care plan accordingly.

The care plans recorded people's preferences and how staff were able to identify if people were happy, for example by their non-verbal as well as verbal communication. Some communication plans were very brief. There was no information about what specific methods were used to help people communicate although some people had no conventional verbal communication skills.

We saw that some care plans did not cover specific health and care needs including disabilities, health conditions and syndromes. Some did not describe the actions needed to keep people safe where there were identified risks.

The format of the care planning system in place at respite services was found to be medically oriented as it was the same as the format used for inpatient services. While there were the four harm risk assessment tools used for blood clots, pressure areas, infections and falls these were frequently not relevant for people who lived in the community and were using short term respite services.

Sufficient capacity

In most services we found that staffing levels were sufficient to meet the needs of people using services.

However in one service we found a staff member supporting a person receiving care, working alone. The staff member had a list of cleaning tasks to do which meant their time was not wholly dedicated to providing care and support to the person.

Staff told us there were sufficient staff on duty to meet people's needs. The manager for the four respite services told us that people's individual support needs were taken into account at each respite period and if they had high needs then some beds would not be used to ensure staffing levels were sufficient. This approach was confirmed with staff who told us that they knew people well so could anticipate situations where there would be increased demands on staff. One relative told us "They also carefully consider the mix of people there to ensure there are no conflicts".

Multidisciplinary working and support

Referrals to community learning disability teams were discussed at multi-disciplinary meetings. There were a

range of disciplines working as part of the team, including nurses, psychologists, learning disability consultants, physiotherapists and occupational therapists. The range ensured people would receive care from suitably qualified professionals. Staff told us there were good working relationships with social services where people required social support.

There was a transition nurse who worked with people progressing from children's to adult services. One staff member spoke to us about their role in specifically supporting people with a learning disability who had developed dementia. We were told that when people were identified as developing dementia a referral was made ensuring early intervention from specialist staff.

Where people accessed respite services we saw records documented which other agencies were involved in providing care to the person. Relatives we spoke with confirmed there was good communication between respite and day services. We saw some review records where a range of agencies had been involved in the review process.

We spoke with staff from a sample of care homes about the support the community learning disabilities team provided to them. They told us the teams were well organised and supportive, and that when staff were off there were systems in place for other staff to provide cover.

Are learning disability services caring?

Compassion, dignity and empathy

We saw that people had been asked how they wished to be addressed and their preferred names were recorded. We observed positive interactions between staff and people using the service. We saw that staff engaged positively with people and received good responses from them and people appeared to be at ease. People told us, "Staff are lovely" and, "I like it here". One person told us they worried about their privacy and described how staff supported them in a way which respected their dignity and privacy.

In one respite service there was a shared bedroom. Staff we spoke with told us that people were offered a choice and it was discussed with them if they were happy to share to a room. They gave us an example of two people who positively enjoyed the experience of sharing with each other. However we saw one feedback form completed after

Learning disability services

a visit where the person stated they would prefer not to share a bedroom. We did not see any records to evidence that discussions had been held with people about their willingness to share a bedroom.

Involvement in care

The level of detail included in care records indicated that people's views and preferences were known. However there were no signatures or records of discussions to show that people had been actively involved in their care plans. Where there were other services and relatives involved in the person's care these were documented.

We spoke by telephone with a number of relatives of people who used the service. We received overwhelmingly positive comments about the service. Comments we received included "I would not change anything", "There is always someone to speak to if I am worried". One relative told us how the support received had been, "Absolutely wonderful."

Trust and respect

People told us they felt comfortable with staff and there was always someone available to speak to if they needed to. We saw staff respectfully and quietly speaking to people throughout our visits. Relatives we spoke with told us they considered that people who used the service were happy to use the respite services. Relatives considered that staff worked well with people. This included how they interpreted people's non-verbal gestures and behaviours. We observed staff working with someone who was upset and agitated. They used positive interactions and communicated well with the person.

Promotion of independence

At the respite services people were supported to cook for themselves wherever possible. The cupboards had pictures on the doors to identify the contents. Menus were drawn up on a weekly basis and staff told us people were involved in deciding what foods were served.

We received largely positive reports from people about the quality of food. In one service we observed that people were not offered a choice at lunch and everyone had the same meal and drink and we observed people were offered few choices. One person who used the service told us that they were sometimes asked what they wanted to eat but not always.

Where people attended day services or colleges their daily routines continued whilst they used the respite service.

This ensured there was a continuity of care and established routines were respected. People told us that staff supported them in a range of ways such as finances, appointments, and medicines. One person told us "life would be more difficult without them".

Are learning disability services responsive to people's needs? (for example, to feedback?)

Meeting people's needs

Relatives and staff told us that following an incident the mini-buses had been withdrawn from the respite services. They told us the decision had been taken rapidly without consultation. Staff and relatives we spoke with told us how this had adversely impacted upon people who used the service as they were now reliant on taxis and public transport.

Many people using the service were not able to communicate with us due to their disabilities. We sought views from families on how the service met people's needs. The information we received was positive with relatives expressing that staff knew people well. This included knowing how they behaved and their medical histories which affected the care they needed.

Relatives described to us how many people had complex needs but they felt that staff were skilled and did their best when providing care to people. We were told how staff responded positively if people became ill or there were emergencies. Relatives all told us they were kept informed of significant events, incidents or changes if they occurred.

Vulnerable patients and capacity

At a focus group with relatives of people who used the service relatives told us most people using the service would not have capacity to make decisions about their care. All confirmed they were consulted about people's care but none had been involved in formal assessment processes. In some care plans we found records of what decisions people could make for themselves but this was not consistent over the four respite services.

Staff told us that capacity assessments were completed where the person was not considered to have capacity. However we saw relatives had made some decisions about the medicines people received but did not see mental capacity assessments or best interests decisions

Learning disability services

documented to demonstrate that the decisions had been reached in people's best interests and in line with the legal requirements of the Mental Capacity Act 2005. Not all we staff we spoke with were able to describe how the Mental Capacity Act 2005 would be used in practice, despite some people not having the capacity to consent to their care. In one service we saw an advocate visited regularly to engage with people and seek their views about their service.

In some services we saw that there was consideration of the person's understanding of money but this was not found to be consistent across all services. Staff told us that some monies were kept safely for people and there were records kept to ensure this was accounted for.

Relatives we spoke with told us that they felt people who used the service were safe, well known to staff and people were understood.

Access to services

Relatives told us that there were assessment processes in place where the manager of the service met with people to assess their needs. We saw the completed assessments in care records. Arrangements were in place to provide ground rooms in all of the respite units for those with mobility problems although in some locations these were limited. We saw equipment available such as hoists to ensure people with mobility problems could be cared for.

Staff told us that the respite units were used variably according to people's needs. There were examples where people used the service regularly for one night each week and other examples where people stayed for a number of weeks to allow relatives to go on holidays. Relatives told us that they had asked if people could be given respite places at short notice as emergencies had occurred. These requests had mostly been met demonstrating that the service was responsive to people's needs. Only one relative told us that emergency respite was easier to access at Ash Green Hospital as opposed to the respite units. One relative described the service as a "Lifeline" which enabled them to provide continued care and support for their adult child at home. Other relatives also told us that they "couldn't cope as well" without the service.

We saw picture signs around respite services to orientate people. These included signs for where food, crockery and other items were stored in the kitchen, as well as what different rooms were. A system had also been developed at one service to use a red or green sign to highlight for some

people which areas they could go into. This had been successful in protecting other people's privacy as red signs were placed on all bedrooms apart from the person's own bedroom which had a green sign.

There were no waiting lists to access the respite services or community learning disability nurses. Staff told us that a single referral system was used and if there was an urgency people could be seen very quickly. However, we were told that there was a delay for people to access outpatient psychology services with currently 18 people waiting for an appointment.

For outpatient services relatives and staff at care homes told us people sometimes had to wait between 30 to 45 minutes past their appointment time. This caused agitation and anxiety for some people. We were told that sometimes relatives/carers had made requests to be seen quicker but these had not been listened to.

Some but not all care planning documents were presented with pictures to enable people to understand them. However we did not find evidence of people being involved in developing their care plans, although their preferences and individual needs were mostly documented.

Learning from experiences, concerns and complaints

We saw some forms that people had completed after their stay to let the provider know how they had found their visit. The majority of feedback stated that stays were "Good" and "Staff were lovely". Only one negative comment regarding a person wanting their own room next time was recorded.

We saw a complaints information leaflet was available in an easy read format to enable people without literacy skills to access this. Relatives told us they knew how to raise complaints but most had not had reason to complain.

Are learning disability services well-led?

Leadership and culture

Staff told us that they received a range of information from the Trust Board and that the Board members were visible and known to them. Staff told us Board members visited the services. Staff also told us they had presented a person's story to the Board to inform them about their work and demonstrate the complexities involved in the person's care provision.

Learning disability services

The managerial arrangements varied at different services. For some services managers were allocated to a number of geographically separate services. Most staff we spoke with told us that managers were visible and supportive to them. However staff did report that managers spent more time in some services than others which they felt affected the support they received and the way the service was run.

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Staff support, training and appraisal

We looked at the online system used for recording staff training and appraisals. There appeared to be different local arrangements regarding supervision arrangements. In

some areas there were group and individual caseload and clinical supervisions at regular intervals. In other areas the systems were not so well established. Staff all told us they received annual appraisals which were timed to coincide with the date when salary increments were due.

We looked at staff training records and spoke with staff who confirmed their training was mostly up to date. Some insulin training was being delivered with a completion date of 30 March 2014. Staff knew about this but had largely not completed it. Staff told us there was access to mandatory training study days. We looked at some training records and found that training was mostly up to date. There was one area where staff had not completed first aid training although they were working alone at times.

Staff meetings were held each month. The minutes recorded health and safety issues and learning from incidents.

Patient experiences and staff involvement and engagement

Staff described to us a range of ways in which they were given feedback on what was happening within the Trust. This included newsletters, information on the Trust's intranet and meetings where ideas and hot topics could be discussed. At one service we saw that a person using the service was included in the interview panel for new staff.

Minor Injury Units

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Derbyshire Community Health Services NHS Trust runs four minor injury units in Derbyshire. Minor injury units provide consultations, advice and treatment for minor injuries and illnesses.

The units are located at Buxton Hospital, Whitworth Hospital at Darley Dale, Ripley Hospital and Ilkeston Hospital. The Ilkeston minor injuries operated 24 hours per day. The minor injury units at Buxton, Darley Dale and Ripley operate between 8.00am – 10.00pm.

During this inspection we visited and gathered feedback from patients using the units at Buxton and Whitworth Hospitals.

Summary of findings

Systems were in place to handle any identify, record and escalate any significant incidents. Staff used the systems effectively and received feedback on the analysis of incidents.

There were suitable systems in place to ensure staff were trained in recognising abuse of adults and children. There were reporting systems and interagency procedures in place which staff used if they had concerns. The services provided effective treatment to patients within acceptable waiting times. There were systems and relationships with other agencies established which meant on-going care arrangements were made to meet patient's needs.

Patients received good care from staff who regarded them with dignity and respect. Patients were kept informed about waiting times and given explanations regarding their care. Staff provided care and emotional support to patients in clean and calm environments. Staff received on-going training, supervision and annual appraisals to ensure they were suitably skilled for their role.

The minor injuries units were responsive to the needs of patients and were highly valued by local communities. Staff had developed an innovative information booklet for children. The involvement of staff did not end when the patient left the minor injury unit and there were systems in place for staff to arrange aftercare for patients.

The service was well led at all levels in the organisation. Staff were well supported by managers and were involved in the plans for the development of the minor injury services.

Minor Injury Units

Are minor injury services safe?

Learning and improvement

Staff used the incident reporting system effectively. Staff told us that it was rare that patients had to wait for more than four hours to receive care. If this had occurred, it was reported and investigated to establish reasons for delays and lessons to be learned. Where safeguarding concerns had been identified these were recorded on the incident reporting system. Staff had a system in place to follow up referrals to ensure they had been received and actioned.

Systems, processes and practices

The minor injury units used a paper records system which did not facilitate easy communication with other agencies or healthcare professionals. Each patient visit was manually inputted into the computer system, often after the visit had taken place. Some hospitals and community services used a system which allowed the immediate but relevant sharing of information across. Staff told us that some information had to be mailed to GPs. There was a risk of delay in information being appropriately shared. Staff told us there were plans to introduce a new computerised records system.

The Royal College of Paediatrics conducted an external review the care children received in minor injury units in 2012. This report highlighted that improvements could be made to the safeguarding procedures in place to help children at risk or being abused. There was a system to identify if children were repeat attenders although this was not robust. As paper records were used, the records of child attenders were retained for three years. As each record was filed, it was examined to check if the child had attended previously. Where there were repeated visits, referrals to relevant agencies were made.

The two minor injury units we visited were clean and hygienic. The curtains in some bays were made of fabric. There was a schedule to replace these on a three monthly basis. The cubicles were small so that patients' feet or shoes could touch the curtains increasing the risk of cross infections. Staff told us there were spare curtains available if they were to become visibly soiled.

Monitoring safety and responding to risk

We saw on the incident reporting system that safeguarding referrals were made where considered necessary. Staff told us they had received training in safeguarding adults and

children and were knowledgeable about the types of abuse that could occur. There were suitable systems in place to report out of hours concerns through the social services arrangements or the mental health crisis intervention service.

Medicines were generally managed safely. Medicines were stored securely, including in fridges where required. Temperatures of drugs fridges were monitored. Staff were not disposing of medicines in accordance with the Trust's policy. Pharmacists visited the minor injury unit to provide a top up service and monitor drug usage at the units.

Anticipation and planning

From analysis of patient attendance, there were known times of increased demand on the service. We saw from duty rotas that increased numbers of staff were routinely on duty at these times.

Are minor injury services effective? (for example, treatment is effective)

Evidence-based guidance

The minor injury units were led by emergency nurse practitioners. These are nurses with the necessary knowledge and skills to independently conduct assessments of patients who present to an accident and emergency department. Some agency staff were employed and the same individuals were employed where possible to ensure staff were familiar with the units and their operating systems.

Sufficient capacity

Since our last visit to Buxton minor injury unit in February 2013 there had been changes and improvements to staffing arrangements. New staff had been appointed, including a nurse who was trained in paediatric care. The matron told us that the team had developed and the training of staff had improved. We saw that the levels of staff available were sufficient to keep waiting times to below four hours with few exceptions. One patient told us they considered there were enough staff on duty and they felt they were suitably skilled and knowledgeable.

Clinical practice facilitators were employed by the Trust to ensure staff training was kept up to date. We spoke with staff who told us they were supported to complete training. At our last visit to Buxton minor injury unit we found shortfalls in staff training. At this inspection we found that

Minor Injury Units

training was up to date or planned. The modern matron told us that the emergency nurse practitioners completed a 'Clinical skills in practice' course; this was accredited by Birmingham University. In one area we saw that health care assistants safeguarding training was not up to date but this was being addressed.

Staff received annual appraisal and regular supervision. Some supervision was specific to aspects of staff roles, for example nurse prescribers received specific supervision from GPs. The Trust also provided group supervision to minor injury unit staff in relation to safeguarding adults and children. Some staff improved their skills by shadowing other staff, for example a healthcare assistant worked with a children's play assistant to improve the experience of children who visited the unit.

Part of the staff training related to the care of sick children. Some paediatric nurses were employed but there was not a paediatric nurse on duty for all shifts. Additional training was completed by staff to ensure they were suitably skilled to meet the needs of children. Some staff had worked in hospitals that provided paediatric care in a shadowing capacity to learn and improve knowledge.

Multidisciplinary working and support

If patients required urgent care which could not be provided at minor injury units, arrangements were made to transport patients by ambulance to accident and emergency units. Staff reported that on occasions there had been some delays due to ambulance availability but this was outside of the Trust's control.

We saw records to demonstrate that staff worked with agencies over a large geographical area as patients using the service may be on holiday or visiting the area.

Are minor injury services caring?

Compassion, dignity and empathy

In the units we visited there were some curtained bays available and some treatment rooms. The treatment rooms afforded patients more privacy during consultations. Staff told us that they tried to undertake initial consultations in treatment rooms which ensured privacy.

Patients were treated with dignity and respect. Patients consistently told us they were positively regarded by staff and treated in a respectful manner. Comments left on the NHS Choices website remarked on this and how staff went "the extra mile."

Involvement in care

Patients were given information regarding the number of staff on duty and the expected waiting time. Patients were given information about ongoing care arrangements and the next steps required to ensure they received the care they needed. Patients told us staff were friendly and informative. We observed patients who were supported by relatives and care staff during their visits. These ensured patients were supported by people they knew.

Patients told us they had been given advice on what they could do at home to ease any pain or discomfort from injuries they had incurred. Where patients needed crutches they were given information on how to use them safely.

Trust and respect

Patients told us they trusted staff and felt safe when visiting the minor injury units. One patient told us "You can't expect anything better than this". There was a high level of satisfaction from patients and the service was valued highly.

Emotional support

Patients told us that staff were "Lovely" and spoke with patients clearly to explain the care processes with them. Another patient told us that, "Staff are very reassuring and very nice so helpful when I was anxious." Patients told us that the units were calm which helped them feel at ease.

Are minor injury services responsive to people's needs? (for example, to feedback?)

Meeting people's needs

There were effective systems in place to track patients' progress as they went through triage to receiving treatment. Information was handwritten with all observations and examinations recorded on one form. This ensured that staff could easily access relevant information in an emergency.

Patients' needs were being met. Patients we spoke with were happy with the service telling us "I don't know what

Minor Injury Units

we would do if it wasn't here". One patient told us they had visited the unit at different times and they had always found the care was delivered consistently even at busy times. One patient on NHS Choices wrote, "If you need emergency treatment for a minor injury go no further than Ilkeston Community Hospital". There were systems in place to supply patients with prescribed medications.

In each minor injury unit there were separate waiting areas for adults and children. Children's waiting rooms had a range of toys. We saw that waiting rooms had emergency call systems in place and CCTV so that they could be monitored should a patient's conditions deteriorate whilst they were waiting.

There was a range of emergency life support equipment available with suitable systems in place to check that most equipment and drugs were fit to use. It was not possible for us to check if some equipment was in date as it had been taken out of the original packaging so the date was missing.

Access to services

The minor injury units were accessible by self-referral. On arrival patients were immediately triaged to ascertain the urgency of their condition and prioritise them according to an evidence based assessment system.

Some of the minor injury units were in rural, remote areas where access to major accident and emergency units was difficult. Patients particularly valued having access to the local minor injury units. One patient told us the service was an asset to the town.

Free parking was available at all sites and the units were accessible for wheelchair users. Staff told us that waiting times were typically one to two hours. Patients told us that they were impressed with the waiting times as they were seen promptly.

Staff told us that 25% of visits to the minor injuries were made by children under the age of 18. Staff had put together a photographically illustrated booklet titled 'Teddy visits the minor injuries unit.' This showed a teddy bear with a range of common injuries. This was used to engage with children and explain to them about potential treatments. Staff told us this was available in all of the minor injury units.

Vulnerable patients and capacity

We saw that where patients with a learning disability or sensory impairments had communication passports available these were considered by staff. Communication passports are records that describe how people understand and communicate with others.

Discharge arrangements

Whilst patients left the units as soon as their treatment was complete staff continued to have a role in ensuring aftercare. This included referrals to and discussions with a wide range of agencies and professionals. This was often complex as some units lay on county borders. The after care arrangements for patients were dependent on the type and extent of injury. Staff told us they had good working relationships with a wide range of agencies and healthcare professionals. This included social services, health visitors, district nurses and community mental health services. Where children had attended the minor injury units health visitors were routinely informed.

Learning from experiences, concerns and complaints

The minor injury units operated a "You said, we did" process. We saw a poster displayed in one minor injury unit where patients' comments were collated and responses were given. There was also a range of compliments about the service displayed.

On the NHS Choices website one patient had been unhappy with the care they received. The Trust had responded to the concerns raised by inviting the patient to contact them in order for the circumstances to be investigated and any lessons learned.

Are minor injury services well-led?

Leadership and culture

At one minor injury unit, staff told us that a Board member had visited in the past week to speak with staff and visit the department. Staff thought the Board were interested in their work and were supportive of the service. They told us discussions had been held about improving the facilities on offer. The four minor injury units were managed by the same modern matron. This ensured a consistency of approach across the services. Staff told us they felt

Minor Injury Units

supported by managers. Staff meetings were held on a monthly basis. Staff we met presented as being passionate about their jobs, proud to work in the minor injury units and committed to their role.

Learning, improvement, innovation and sustainability

The Royal College of Paediatrics conducted an external review in 2012. A number of recommendations were made in the report, finalised January 2013, in relation to caring for children during the night. The Trust took action to mitigate risks by reducing the opening hours of two units.

The Trust monitored this risk through its Quality and Safety Committee risk reports to the Board. The Trust was working with the out of hours provider and advanced nurse practitioners to come up with solutions.

At the time of our inspection the minor injury unit at Whitworth Hospital was in temporary accommodation while improvements were being made to existing facilities. Suitable arrangements were in place to enable the service to continue whilst works were in progress, although capacity was temporarily reduced. Staff told us they had been consulted and involved in the planning of the improvements ensuring that the environment would be suitable and fit for purpose.

Dental services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Derbyshire Community Health Services NHS Trust provides dental services for children and adults who require specialist support which prevents them from receiving routine dental treatment with a family dentist.

During this inspection we visited, and gathered feedback from patients using, the following dental clinics:

- Dental Access Centre, Leicester
- Long Eaton Dental Clinic
- Melton Mowbray Dental Clinic
- Merlyn Vaz Dental Clinic, Leicester
- Mill Hill Dental Clinic, Derby
- Swadlincote Dental Clinic

Summary of findings

Patients received good dental care and treatment which was provided in a timely way. There were systems in place to keep patients safe. Staff treated patients with respect and dignity.

Dental services were generally responsive to patient's needs and wishes. Clinic appointments could be made easily and quickly. There were long waiting times for treatments which needed to be done under full sedation.

Staff were trained and supported to carry out their role. Dental service improvements were made in response to patient feedback and a robust audit framework. The dental services were well-led. Leadership and communication at all levels were open, supportive and inclusive.

Dental services

Are dental services safe?

Learning and improvement

Dental staff had a good awareness of the mechanisms for reporting incidents and safeguarding concerns. Incident reports showed what learning had been gained and how systems were changed as a result. For example, the placement and monitoring of liquid hand gels in public areas had been revised as a result of incidents recorded.

Systems, processes and practices

Staff told us they had been trained in safeguarding arrangements for children and adults. They demonstrated clear understanding and knowledge of the processes. Records showed where staff had appropriately used safeguarding alert processes when issues had arisen.

Monitoring safety and responding to risk

All of the dental clinics we visited were clean and hygienic. Infection control audits were carried out regularly and the results of audits were used to inform improvements in practice. Staff carried out decontamination procedures in line with national guidance. Patients told us they felt safe using the dental services and could talk to staff about any anxieties they had.

Anticipation and planning

Staff in some areas of the dental service experienced complex and sometimes aggressive situations. They told us they were trained to deal with these types of situations and felt managers supported them appropriately. Systems were in place to ensure the safety of staff such as alarm systems and phone alert protocols.

Are dental services effective?

(for example, treatment is effective)

Evidence based guidance

Patients told us staff were well trained to support them with any of their specialist needs. One patient told us "Treatment here has been excellent; cannot fault it." Other patients said the services were child friendly and we saw waiting areas were well equipped for children.

Staffing arrangements

We saw training for dental staff was up to date or planned. Staff told us the training available helped them to fulfil the training requirements of their professional body, the

General Dental Council (GDC). Staff had regular supervision and an annual appraisal. Regular staff meetings were also in place and staff told us they shared learning experiences and skills with each other. We found there were enough dental staff to meet patients' treatment needs in each clinic. Two clinics did not have dedicated reception staff. This meant patients had to wait for dental staff to come out of the surgeries before they could have their attendance acknowledged and they were not always informed in a timely way that their appointment may be delayed. This also meant telephone calls could not always be answered in a timely way and patients had to wait for a response to messages left on the telephone answering service.

Multidisciplinary working and support

Staff told us they regularly worked in other clinics across the trust. They said this helped them to develop their skills and they could share good practice with other colleagues.

Co-ordination with other providers

Staff told us information systems in their own localities (Leicestershire and Derbyshire) work well and enable good networking between clinics. They told us the information systems between Leicestershire and Derbyshire areas were not as robust and this was mainly due to computer systems not being fully linked.

Effective care delivered close to home

Patients told us how their care and treatment was well co-ordinated between their own dentist and the trust dental service. Records confirmed this.

Are dental services caring?

Involvement in care

Patients told us they were fully involved in all aspects of their care and treatment. They said dental staff discussed treatment plans, costs of treatment and long term support with them. One patient told us the dentist had respected their decision not to have recommended treatment.

Trust and respect

Patients told us they were treated with respect and dignity at all of the dental clinics we visited. They said staff were reassuring and gave them confidence. One patient told us they were "Treated absolutely brilliant. The dentist explained everything and didn't hurt me." Another patient said, "This service is brilliant."

Dental services

Patient understanding of their care and treatment

Patients told us they were kept well informed about things like dental hygiene, health promotion and emergency dental services. Information posters and leaflets were available in all of the dental clinics. Interpreter services were available to patients and staff told us this service had been effective when they had used it. We found there were few clinics that had information available in easy read or alternative language formats. This meant some patients may not have access to all of the information they need or want.

Compassion, dignity and empathy

Parents of children who attended the clinics told us dental staff were very good at calming and reassuring their children. They said staff spoke with the children in a way they could understand and appointments were never rushed. Some parent told us about a particular dentist whose approach with children was “fantastic.” One parent said, “If only he could show other dentists the right way to treat children.”

Are dental services responsive to people’s needs? (for example, to feedback?)

Meeting people’s needs

Patient’s needs were being met. Patients told us they were able to get appointments in a timely way. They said dental clinics responded quickly to referrals from their family dentists and courses of treatment were carried out quickly. Most patients attending the Dental Access Centre told us they could get emergency appointments very quickly. One patient said, “I rang this morning and got through straight away and at 11am we are here, that’s great.” One patient told us they had to ring several times before their call was answered.

Access to services

Information we received from the Trust and from talking with patients and staff showed there were long waiting lists for treatments which required the patient to be fully sedated. Some patients had waited more than 10 months from their referral to receiving an assessment. The dental service manager for the Leicester area told us they had secured extra funding to reduce waiting times. Some patients told us they had raised issues about the lack of

suitable car parking facilities at several of the dental clinic sites, especially where disabled parking was required. One patient told us they had missed their appointment and had to wait longer to be fitted in to the clinic.

Vulnerable patients and capacity

Staff demonstrated up to date knowledge around issues of consent and capacity to make decisions. Patients told us they were asked for their consent to treatment at each visit and this was recorded in treatment notes. Where patients did not have the capacity to consent to treatment, best interest decision making was recorded.

Learning from experiences, concerns and complaints

We saw patient feedback and any complaints were used to improve the services provided. For example, staff training in customer care over the phone had been implemented in one area as a result of a complaint. A television set had been placed in another clinic waiting area as a result of patient feedback.

Staff told us the services were monitored using a system of score cards. This included monitoring of areas such as patient satisfaction scores, staffing and vacancies, compliments and complaints and service delivery. We saw the monitoring process had enabled the trust to take actions such as moving some clinics with limited access to alternative locations better suited for patients. Staff told us the trust provided a responsive maintenance service for equipment. They said any requests for work were completed in a timely way. We saw maintenance and servicing records which confirmed this.

Are dental services well-led?

Leadership and culture

Staff told us they felt well supported by their managers. They said they were able to share their opinions; they felt listened to and they had a voice within the wider trust. We also found each clinic had regular staff meetings which enabled sharing of trust based information and good practice. The Chief Executive of the trust sent a weekly email to all staff to keep them informed of events within the trust.

Dental services

Learning, improvement, innovation and sustainability

We found a positive climate within each of the dental clinics we visited. Staff were motivated within their roles and they demonstrated commitment to continual improvement of their services. One member of staff told us, “I would recommend working here to other dental staff.”

Elective care

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Derbyshire Community Health Services NHS Trust provides elective care services for adults at a number of locations, including locations in Leicestershire which are not owned or managed by the Trust.

These services include outpatients and day case surgery including orthopaedics, hand surgery, ear, nose and throat, ophthalmology, gynaecology, urology, and endoscopy. All surgical patients are admitted as day cases and usually referred by their GP. The quality of elective care services provided at Ilkeston Hospital at the Diagnostic and Treatment Centre is reported in the Ilkeston Hospital Report.

During this inspection we carried out announced visits to the following locations in Leicestershire:

- Hinckley Health Centre
- Hinckley Hospital
- Melton Mowbray Hospital
- Loughborough Hospital

We carried out further unannounced visits to Hinckley Hospital and Melton Mowbray Hospital.

All of the services in Leicestershire are transferring to a new provider in April 2014.

Summary of findings

Generally services were safe and risks associated with the poor maintenance of the premises and some outdated equipment were being managed. Staffing levels on all the units we visited were safe. Staff moved between units and departments to ensure sufficient numbers of staff and minimise the likelihood of cancellation of lists. New measures had been put in place to prevent further breaches of patients' confidential personal information.

Patients were very happy with the care delivered at the units we visited and appreciated being able to attend a location close to home. Care and treatment was effective although there were few clinical audits to monitor outcomes and drive improvements. Care was personalised and patients were treated with dignity and respect. There were limited facilities for refreshments for patients and visitors. The Trust responded to patients' feedback and complaint.

Staff were supported through regular appraisal and access to training. Staff told us the Trust and local services were well-led and they felt informed about forthcoming changes. There was an open reporting culture; staff were encouraged to raise and report issues, although not all staff felt they received satisfactory feedback when they did.

Elective care

Are elective care services safe?

Safety in the past

In 2013 there were a number of incidents at Hinckley Hospital regarding mis-handling of patients' confidential personal information. In May 2013 patient records were found in a local park. A rapid response investigation found the hospital's security was not robust and some essential measures were not in place. However there were further incidents between August and December 2013. Since December, patient records have not been handled by portering services. Security has been increased, with for example, more coded locks on doors and only current records being kept on site.

Systems, processes and practices

World Health Organisation (WHO) safety checklists were used at all the theatres we visited. We saw that the environments were clean and tidy at all four sites, patients told us they had no concerns about the environment. At Hinckley Hospital the décor needed updating, for example, we saw paint flaking off the walls and old metal windows sills were in need of attention.

None of the day case units had access to overnight beds if a patient was not well enough to go home after surgery. They were transferred by ambulance to acute hospital, and there was a protocol in place to support this.

Monitoring safety and responding to risk

Staff and managers told us a key challenge for them was managing health and safety risks at Hinckley Hospital. For example, the main corridor was carpeted, which increases the risk of infections. The managers wanted to replace it with more suitable flooring but had been unable to agree with the building owners on this matter.

The environment in the theatres at Hinckley Hospital was of particular concern to us. There was no piped oxygen or suction equipment in the theatre or recovery room. Some of the equipment was out of date and the environment was in poor condition. However, we were assured that risk assessments were completed annually and that systems were in place to minimise the risk these issues created.

Are elective care services effective? (for example, treatment is effective)

Evidence based guidance

All patients were screened before being put forward for day case surgery. Anyone considered "high risk" was screened out. All patients attending for day case surgery were subject to pre-assessment. Patients who would have a general anaesthetic attended a clinic run by the nurse; other patients were sent a questionnaire. One member of staff told us that the return rate for the questionnaires was low, and consequently patients were turned away on the day of surgery.

Monitoring and improvement of outcomes

There was a lack of formal clinical audit taking place for example around post-operative infection audits or the application of the Trust's policy on venous thrombo-embolism (VTE). We spoke with staff and found that most of them understood the correct procedures and saw properly completed assessments. Staff at Melton Mowbray Hospital 'phoned patients the day following surgery to check any adverse signs or symptoms.

Sufficient capacity

Staffing levels on all the units we visited were safe. None of the patients we spoke with expressed concerns about access to staff when they needed them, and people told us they felt safe. Managers told us that staff move between units and departments to ensure sufficient numbers of staff and minimise the likelihood of cancelled lists. On the day of our visit we saw this taking place. Staff told us that they were reliant on surgeons coming from Leicester for clinics and theatre lists. Lists started late due to consultants not arriving on time, approximately once a week, but as lists were not usually full, time could be caught up.

Multidisciplinary working and support and care delivered close to home

Patients were very positive about their care being delivered close to home. People told us they liked being treated at a smaller hospital and this made them feel less anxious about their care.

Are elective care services caring?

Compassion, dignity and empathy

Patients spoke highly of doctors and nurses. Patients told us that nursing staff have time to talk to patients, and they consider the care very personalised. Staff were sensitive to the privacy and dignity for patients. For example, they had made changes to gowns to preserve modesty.

Elective care

Involvement in care

Patients told us that staff answered all their questions and felt everything was explained. This helped to reduce nervousness and anxiety. One patient said I was “treated like a person.”

Trust and respect

Many staff told us they were prepared to “go that extra mile” for patients and cited a number of examples where they did this. During our visit we observed positive care at all four sites. Staff were polite and helpful to patients and treated them respectfully.

Emotional support

Staff told us they had a “family approach” and told us they did not think the transfer to the new provider would change the way they care for patients.

Are elective care services responsive to people’s needs?

(for example, to feedback?)

Meeting people’s needs

Patients felt care and treatment was delivered at a pace that reflected their needs. Staff told us that because caseloads were low they could deliver highly personalised care. If a patient was not well enough to go home following day case surgery, staff would stay late until the patient felt better or they were transferred to an acute hospital. Staff told us this happened with laparoscopic hernia patients more than any other. This list at Hinckley Hospital was in afternoon and could not be moved to the morning as consultants had clinic then. There were limited refreshment facilities at the sites we visited.

Access to services

All patients we spoke with commented that they liked care being delivered closer to home, and had been satisfied with their access to the service.

Learning from experiences, concerns and complaints

The Trust responded to patients’ feedback and complaints. There were comments cards for patients available in Melton Mowbray Hospital. These were reviewed monthly and staff were told of the outcome. None of the patients we spoke with had made a complaint but told us they would be confident to do so if the need arose.

Are elective care services well-led?

Vision, strategy and risks

We received high praise from staff about communications from the Trust. They felt well informed and included in what was going on. Staff felt the transition to the new provider was being managed well, although a minority said they felt vulnerable about what was going to happen. The Trust was in the middle of a series of briefing sessions for staff on the transition. Staff that had attended had found them useful. Some staff stated they would have liked more feedback from the senior leaders in the Trust and felt they could have been more visible. Patients felt care was organised and well managed but were unaware or transfer to the new provider.

Quality, performance and problems

Although we found evidence of audits taking place we felt that staff were not fully engaged in the audit process. We could not find any evidence of changes as a result of audit or what learning had taken place for staff.

The majority of staff we spoke to said they had had an appraisal and were able to access mandatory training since the implementation of e-learning. There was a mixed response to induction, implementation appeared to be inconsistent. Staff were aware of clinical supervision; a new system was being introduced.

Leadership and culture

There was an open reporting culture, staff were encouraged to raise and report issues. Monthly governance meetings were held where feedback on reported risks was given. How this was cascaded to staff varied across the sites. When we asked staff if they received feedback following reporting an incident or concern, there was a mixed response. We noted in the management structures there was a gap between band 6 and band 8a nurses. This could potentially have an impact on information flow.

Learning, improvement, innovation and sustainability

We found that nursing staff were enthusiastic about innovation but there was limited success in implementing some of these. Staff felt that no one was prepared to make a decision or take action due to change over of provider.