Wiltshire Health and Care LLP

1-2642739822

# Community health services for adults

## Quality Report

Chippenham Community Hospital
Rowden Hill
Chippenham
Wiltshire SN15 2AJ
Tel:01249 454395
Website:www.wiltshirehealthandcare.nhs.net

Date of inspection visit: 27, 28 & 29 June and 6 July 2017
Date of publication: 09/10/2017

# Summary of findings

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| 1-2699740288 | Chippenham Community Hospital | Community nursing team, tissue viability team, diabetes service, orthotics, respiratory service, outpatients service, dietetics service | SN15 2AJ |
| 1-2700153220 | Savernake Community Hospital | Community nursing team, occupational therapy service, physiotherapy service, outpatients service | SN8 3HL |
| 1-27200381463 | Trowbridge Community Hospital | Community nursing team, neurology service, physiotherapy service | BA14 8PH |
| 1-2642739822 | Amesbury Health Centre | Community nursing team continence service, physiotherapy service, occupational therapy service, podiatry service | SP4 7LY |
| 1-2642739822 | Melksham Community Hospital | Community nursing team, physiotherapy service, wheelchair service | SN12 7NZ |
| 1-2700381546 | Warminster Community Hospital | Community nursing team, physiotherapy service, Home First team | BA12 8QS |
| 1-2642739822 | Salisbury Health Centre | Community nursing team, physiotherapy service | SP1 3SL |

This report describes our judgement of the quality of care provided within this core service by Wiltshire Health and Care LLP. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Wiltshire Health and Care LLP and these are brought together to inform our overall judgement of Wiltshire Health and Care LLP.

# Summary of findings

## Ratings

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

We rated community health services for adults as outstanding because:

- The services were monitoring safety effectively and we saw evidence that learning occurred when things went wrong. There was a positive culture around incident reporting which helped promote learning and service improvement for patients. Staff received feedback from reported incidents and told what actions had been taken. There were arrangements in place to safeguard patients from abuse.
- There was a holistic approach to assessing, planning and delivering care and treatment to patients. Relevant and current evidence-based guidance, best practice and legislation was used to develop how the services, care and treatment were delivered.
- The service monitored patient outcomes and undertook a range of audits to promote best practice. Technology was used to enhance the delivery of effective care and treatment and was being positively embraced by community staff.
- Community teams responded quickly and effectively in response to end of life patients who were being discharged from an acute setting.
- Feedback we received from patients was universally and overwhelmingly positive about the compassionate and caring approach from the community staff. This was across all the teams and different specialist services. Patients thought the staff went the extra mile and the care often exceeded their expectations.
- Wiltshire Health and Care had come into operation in July 2016 with a clear programme and plan for the delivery of community services. The services were flexible, provided choice and ensured continuity of care for patients.
- There was evidence of excellent work being done with local services to promote better care and treatment and help prevent hospital admission.
- The service was very responsive to meeting the preferred needs of end of life patients.
- A strategy was outlined in a delivery plan and included a five-year programme of change needed to support the vision. The governance framework ensured that responsibilities were clear and quality, performance and risks were understood and managed.
- There was a programme of clinical and internal audit, which was used to monitor quality and systems, identifying where action should be taken.
- Services were provided with outstanding leadership in the community teams and specialist services. We found there was a positive and motivated culture within the various teams. Staff expressed pride at the quality of service delivered and the care and treatment patients were afforded.

**However:**

- There was an issue with safe storage of adrenaline medication whilst travelling, and the service had not yet implemented a sepsis pathway with related training for community staff.

# Summary of findings

## Background to the service

This inspection report relates to the community services for both adults, and a small number for children. This includes the outpatient services run from the community hospitals and other locations. The provision includes 11 community teams, which are made up of nurses, occupational therapists, physiotherapists, healthcare support workers and rehabilitation support workers. There are also other specialised teams which include podiatry, tissue viability, diabetes, neurology, orthotics, dietetics, physiotherapy, continence, wheelchair services, and respiratory.

The services are provided for the whole of Wiltshire, which has a population of approximately 480,000. In an average month, the service supports 6,500 patients and has 45,000 contacts with these patients. Services are provided by approximately 615 staff.

The provider has set out a five year programme of change themes and a service delivery plan until 2019. The five year priorities are listed as:

1. A service delivered in partnership.
2. Higher intensity care.
3. Best practice:normal practice.
4. Healthy independent lives.
5. Community based urgent care.
6. Leading the way.
7. Broadening Skills.
8. More for your money.

To undertake this inspection we visited the locations where services were delivered. We talked with 72 staff and 51 patients. We looked at 12 sets of patient records. We talked with other stakeholders and commissioners of services. We observed practice and looked at clinic areas and equipment. As part of the process, we looked at records, policies and other documentation.

## Our inspection team

Our inspection team was led by:

**Chair:** Julie Blumgart

**Inspection lead**: Alison Giles

The team that inspected the community services included four CQC inspectors and two specialist advisors who were qualified community health professionals. We also used experts by experience to contact and talk to patients about the services they used.

## Why we carried out this inspection

We inspected Wiltshire Health and Care LLP as part of our comprehensive community health services inspection programme.

## How we carried out this inspection

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

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

To undertake this inspection we visited the locations where services were delivered from. We talked with 72 staff and 51 patients. We looked at 12 sets of patient records. We talked with other stakeholders and

# Summary of findings

commissioners of services. We observed practice and looked at clinic areas and equipment. As part of the process, we looked at records, policies and other documentation.

## What people who use the provider say

People who used the services were universally positive about the staff and their caring and professional approach. There were positive comments about reception and telephone staff. People told us the staff would go the extra mile and provided compassionate care. Treatments were well explained and staff were flexible in arranging appointments wherever possible. We were told that communication was open, effective and informative.

## Good practice

We considered the following to be areas of outstanding practice:

- The leadership of the specialist community teams.
- The innovative practices for managing continence care such as trial without catheter and the use of Biofeedback in managing female continence.
- The responsiveness of the community teams to patients receiving end of life care.
- The strategies in place to support admission avoidance and support early discharge from hospital such as the high intensity care work and the early stroke discharge team.

## Areas for improvement

**Action the provider MUST or SHOULD take to improve**

**Action the service SHOULD take to improve**

- Store all medications used by staff working in the community teams securely, safely and in line with manufacturers' guidance.
- Ensure that there is a sepsis pathway in place and that staff working in the community teams have training in relation to this
- Ensure that a clinical supervision policy is understood for the community services, and consistently implemented across the service.
- Ensure that all prescription pads used by community teams are stored securely.
- Ensure that all equipment used by community teams is serviced and tested at the recommended intervals.
- Review the environment where the orthotics outpatient clinic at Chippenham Community Hospital is held, due to access difficulties for people who are disabled.

Wiltshire Health and Care LLP

# Community health services for adults

**Detailed findings from this inspection**

Good

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We rated the safety domain as good overall because:

- The services were monitoring safety effectively and we saw evidence that learning occurred when things went wrong. There was a positive culture around incident reporting which helped promote learning and service improvement for patients. Staff received feedback from reported incidents, and told what actions had been taken.
- There were arrangements to safeguard patients from abuse. The safeguarding forum for adults and children supported the organisation in developing and monitoring policy, guidelines, incidents and training. Staff understood their responsibilities for reporting abuse, and were aware of the provider's policies and procedures.
- Managers and staff we spoke with said their caseloads were generally manageable but staff shortages meant that many staff were working to capacity.
- The provider had a lone working policy and there were processes to promote safety for staff working in the community.

However:

- The provider did not have a healthcare pathway for the detection and management of sepsis in the community.
- Some storage of adrenaline medication was not in line with manufacturer's instructions.
- Prescription pads used by nurses were not always securely stored.
- We found some shortfalls in the recording of routine maintenance.

### Detailed findings

#### Safety performance

- The track record on safety was good. A range of safety information was being monitored and fed into service improvement. The provider had an electronic adverse incident reporting system, and all staff we spoke with were aware of how to use this system and report incidents. We saw evidence that reported incidents were discussed at team meetings and feedback was provided.

Good

# Are services safe?

- Wiltshire Health and Care LLP reported four serious incidents requiring investigation between 4 July 2016 and 25 March 2017. Two were attributed to the community teams. Both incidents related to pressure ulcer care.
- In one instance, the patient had not been identified as someone who needed to be included in a community team caseload. Therefore, it was not known which professionals were to be involved and who was immediately accountable for treatment.
- In the second, the patient was identified as someone who needed to be included in the community team caseload but there had been concerns about the documentation, assessment and review of wounds.
- We saw evidence that learning from both incidents was disseminated through the community teams. The learning and issues involved were discussed at team meetings.
- Each community team had a safety thermometer referred to by the provider as 'Red Wednesday'. On a set day each month staff recorded the required data on avoidable patient harm to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included all and new pressure ulcers (category two and more serious categories: three and four) and patient falls with harm. The report also included catheter and urinary tract infections (UTIs). Staff said the data was fed back to them at team meetings. We also saw in the various community team offices the latest safety data was included as part of the performance dashboards, which were displayed and regularly updated. Other performance information such as waiting times and themes and trends were displayed on the patient safety thermometers in prominent places in community team bases.
- A 'harm free care' group met monthly (or more often if required) to understand the level of safety in care provided. Staff grades who attended included band three (healthcare assistants) and above into the nursing grades. The group reviewed all serious incidents. For example, when reportable pressure ulcers occurred, the group would determine whether the pressure ulcers were avoidable or not. They would document and share the learning and actions needed to prevent or limit reoccurrence. We saw learning included in team meeting minutes, anonymised root cause analysis investigations displayed prominently in some community teams, and email correspondence. The group also reviewed safety thermometer indicators, mortality rates, and themes and trends.
- Staff understood their responsibilities to raise concerns, record safety incidents, and near misses, and report them. We saw electronic records of a range of incidents reported including pressure ulcers, safeguarding alerts for adults and children, and incidents involving medication.
- Safety goals or objectives had been set. For example, community teams were aiming to reduce the number of avoidable pressure ulcers, and this was monitored by team leaders, senior managers and by commissioners.

### Incident reporting, learning and improvement

- There was a positive culture around incident reporting which helped promote learning and service improvement for patients.
- Staff we spoke with said they received feedback from reported incidents when this was appropriate and were told what actions were taken. Learning from incidents was shared across the service with reported incidents being discussed at team meetings and information being disseminated throughout the different services and teams.
- Patients who used the services of the community teams were told when they were affected by something that went wrong. They were given verbal and written apologies and informed of any actions taken as a result. We spoke with staff who had spoken with patients and been involved in this process.
- Staff were encouraged to report incidents using the provider's electronic recording system. The community team leader and clinical lead saw all incident reports. Staff received feedback from their manager following the reporting of an incident. A team leader showed us how they managed incident reports. The incident report we saw related to a patient reporting they were discharged from hospital with a cannula in their arm (tube into a vein). The team leader told us they would first go back to the member of staff who reported this, as the hospital name was not included and they felt this incident needed to be fed back to them for learning. They showed us the areas they needed to populate and the section for feedback to the member of staff via e-mail. At team meetings, the number and type of

incidents were shared with staff and they were displayed on their 'dashboard' (monthly data information) in team rooms. For example, the Chippenham community team had reported 33 clinical incidents for May 2017. These included pressure ulcers and falls/slips. In the physiotherapy outpatients at Savernake Community Hospital, they had reported no clinical incidents for May 2017.

- A community team leader told us that a full review or root cause analysis of serious incidents took place. While they had not had a specific training for completing these, they had done them for a number of years and felt confident in completing them. They also supported other junior staff to undertake them for learning. The outcomes of these were fed back at team meetings. Team members we spoke with were able to describe the feedback that had been provided following the reporting of the two serious incidents that had been reported in the community services over the previous twelve months. This had included the reviewing of certain sections of paperwork, reminders about how some recording should be completed, and discussions around liaison with colleagues working in the community hospital. All staff we spoke with told us incidents were viewed by the organisation as an opportunity for learning.

### Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were able to provide us with a detailed explanation of when duty of candour was applied. We were told of two examples where an apology and explanation was provided to family and to a patient.

### Safeguarding

- There were arrangements to safeguard vulnerable people from abuse that reflected the relevant legislation and local requirements. The safeguarding forum for adults and children supported the organisation in developing and monitoring policy, guidelines, incidents and training. It worked in collaboration with the wider Wiltshire Safeguarding Adults' Board and the Wiltshire Safeguarding Children's Board.
- Staff understood their responsibilities and were aware of the organisation's policies and procedures. Staff we spoke with were clear about the reporting process and the people they could contact for advice. We were told safeguarding was regularly discussed at team meetings.
- Staff who worked directly with children were required to complete level three childrens safeguarding training. Support and advice was available from the organisation's lead on childrens safeguarding.
- Staff were aware of the systems to make sure patients were safe. The provider's policy on safeguarding was accessed via the computer system and there was an app that enabled staff to go straight to the guidance and policy.
- Staff told us they all knew where to find the form in their computer system to report safeguarding concerns. These referrals went straight to the local council and staff were sent an acknowledgement when they were received. The organisation had appointed safeguarding leads and staff were able to obtain advice and support if they were unsure about a referral. Staff we spoke with were very positive about the accessibility and support provided by the safeguarding lead, who also had a lead role in providing training and developing policies and procedures. Two community managers we spoke with commented that the enthusiasm, support and passion from the safeguarding lead was a great benefit to all their team members. We were told it helped to promote confidence and understanding in individual staff and consequently the safety of patients.
- Safeguarding information was visible between community teams on the electronic care record used by all staff. Staff also used a 'safeguarding application' on their mobile electronic devices when away from the office base. This enabled staff to share concerns more effectively.
- Staff were completing training that was being audited and monitored. We found high levels of training being completed in all teams of between 94% and 100%.
- Staff were aware of Prevent. Prevent is part of the Government's counter-terrorism strategy "Contest" and aims to stop people becoming terrorists or supporting terrorism. It is described as "the only long term solution to the threat we face from terrorism. Prevent focuses on all forms of terrorism and operates in a pre-criminal space, providing support and re-direction to vulnerable individuals at risk of being groomed in to terrorist activity before any crimes are committed."

Radicalisation is comparable to other forms of exploitation and is therefore a safeguarding issue staff working in the health sector must be aware of. Staff gave us an example of when they made a safeguarding referral as they had felt a patient was being radicalised.

### Medicines

- In general, there were safe arrangements in place for the managing, administering and storing of medicines. However, we found a shortfall in the safe storage arrangements for anaphylaxis medicines and around the storage of prescription pads.
- The service was using the policies, standard operating procedures and guidelines for the medicines optimisation from its predecessor organisation and had started a process of review and reissue for this organisation. Service oversight of medicines optimisation was achieved through the medicines' governance group.
- Community nurses told us they had adrenalin medication for giving injections in case of anaphylaxis (anaphylaxis is a severe and potentially life-threatening reaction to a trigger such as an allergy). The medication was often stored locked in the boot of their cars where it would be subject to variations in temperature. However, this medication is sensitive to temperature change, which can reduce its effectiveness, and such storage does not comply with national guidelines. Manufacturer's recommendations were that the storage of adrenaline should be at temperatures below 25 degrees centigrade. Adrenaline was stored in staff vehicles and only the replacement stock was being stored in areas where temperature could be partially controlled. Temperatures in staff vehicles and in community bases were not monitored.
- Arrangements for the security of prescription pads were not always appropriate. There was variable practice in the storage of prescription pads. Some staff ensured they were held in locked cabinets at staff bases at the end of the day and some staff took them home but they were not kept locked away, as best practice requires.
- There were processes for the management of patient group directions. However, those in use were unapproved copies. When we raised this with senior staff on the organisation, they took immediate action to correct this. Patient group directions (PGDs) allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The PGDs we saw were not all in date, those that were in date were not always signed as required by the person who could administer the medicine. Of those that were signed, not all were countersigned by an authorising manager. When we raised this with a staff member, immediate action was taken to address it by raising it with the relevant community team lead.

### Environment and equipment

- In general, we found the maintenance of equipment and the use of facilities kept people safe and avoided unnecessary risks. Appropriate equipment was readily available and repairs when reported were attended to promptly. We had feedback from patients about the care they received in their homes, which was very positive. Patients told us that equipment was supplied promptly and in working order. We heard that staff used the correct patient handling procedures and that patients felt they received safe care.
- Managers in the community teams completed monthly health and safety audits with results being sent in centrally to be considered by the estates team. This helped ensure that any repairs required to equipment or safety issues around clinic areas were noted and addressed.
- There was a clinical products and equipment review group. The purpose of the group was to be responsible for all aspects of clinical commodities and equipment purchased, trialled, and used by staff. The objective of the group was to provide safe, suitable quality and cost effective clinical commodities and clinical equipment in the community with recommendations being passed to provider senior management.
- We found some shortfalls in the recording of routine maintenance. For example, we checked the syringe drivers held at the Chippenham base for community nurses and found three had exceeded their service date. Staff told us they would get as many as they could sent to be serviced. They used an external provider for their servicing. Staff told us when they took syringe drivers out to patients they were in a box with the stock needed to set up the syringe driver. For example, lines, syringes and spare batteries.
- In one of the physiotherapy clinics, we saw equipment was available for bariatric patients, and this included therapy plinths.

Good

# Are services safe?

- In the orthotics outpatient clinic at Chippenham Community Hospital, we found the environment was not suitable for all patients. For example, there was a step up into the room, which was difficult for patients with mobility issues, and we observed two patients struggling with this. There was also no direct wheelchair access. If a patient in a wheelchair needed to use the clinic they had to be taken through the podiatry clinic and then into the orthotics room. Staff told us they thought new premises at the hospital were being looked into. The provider had an improvement plan in place.
- Patients who received wound care from the community teams were given dressings based on a set formulary. The formulary was devised by the tissue viability team and all staff were directed to use certain dressings from this formulary. Stocks of wound dressings were held at each community base and staff took out a small amount each week. This was to prevent many dressings being left at a patient's home and so avoid waste. At the Chippenham base, staff told us they were stocked up each week and dressings were used in date order again to prevent wastage.
- Community nurses told us they were able to provide continence pads to end of life patients on a short-term basis, as they stored these at their bases for this purpose.

## Quality of records

- Records were written and managed in a way that kept people safe and protected confidentiality. Records were regularly audited and feedback provided to staff.
- The provider used a computer system for patient records and community staff had access to this system via mobile devices. Where patients were visited in their own homes, a reduced selection of records was stored. Staff told us they felt the system was very good and they mostly had access to all the information they needed.
- We looked at a sample of records across the full range of services. We found electronic records were up to date, detailed and provided staff with a wide range of information.
- Not all outpatients' clinics had access to the provider's computer system, so some were still using paper records. However, staff said there were plans to address this and provide access to all teams in due course.

## Cleanliness, infection control and hygiene

- We saw good standards of cleanliness and hygiene were maintained in all the clinic areas we visited. Staff were clear about who was responsible for cleaning different areas and audits of infection control and cleaning were undertaken by a nominated person. We saw that staff observed the provider's policies on infection control when visiting patients in their homes.
- Community staff all carried protective clothing such as gloves and aprons. They also had hand-sanitising gel to prevent the risks of cross infection. We were told that supplies were kept stocked up and that protective equipment was always available.
- We observed community nurses working in patients' own homes, and saw they washed their hands when able and used personal protective equipment including hand sanitising gel, gloves and aprons.
- We received positive feedback from patients. Comments included "when we've seen the nurses they've always washed their hands before and after seeing us" and "they wash their hands here. They bring aprons as well and throw them away afterwards", and "they always wash their hands and put on an apron before they touch my wound."
- In the clinics we visited, we saw green stickers were placed on equipment to identify when they were last cleaned.
- Arrangements for managing waste and clinical specimens kept patients safe. We looked at the arrangements for disposal at three locations we visited and saw there were appropriate arrangements in place that were monitored and effective. There were the correct disposal bins in place for the different types of waste. These were regularly collected and emptied and guidance was displayed for staff.

## Mandatory training

- Training was provided for all staff to ensure they were competent to perform their roles. There was a designated list of mandatory training, which covered safety systems, processes and practices. Staff we spoke with were positive about the provider's commitment to their training, the quality and the support they were provided with to complete this.
- Senior staff told us mandatory training was accessed via their computer system. This provided some flexibility to staff on when and where this was completed. Their

mandatory training included equality and diversity, dementia, safeguarding for children and adults, fire safety, and infection control. There was a target of 90% for the completion of mandatory training, and this was monitored on the performance dashboards that were produced for each area team. The majority of teams were achieving this target or exceeding it. For example, the Chippenham community team had just exceeded the 90% target for completion. Where the target was not being met, this was being monitored by the team managers. The reasons for the shortfall were recorded and action planned to address this. In the examples we saw this was due to the number of vacancies in a team and the difficulty of recruitment.

- Health support staff working on the new project 'Home First' service were given a comprehensive induction programme. They completed the National Care Certificate skills training to meet the needs of patients they would be visiting.

### Assessing and responding to patient risk

- When referrals were received by each community team, they were triaged to see if the risk to the patient was urgent. They were then passed to the relevant team who were best placed to meet the patient's assessed needs.
- The provider did not yet have a sepsis pathway and no specific training for the identification and management of sepsis had been provided to the community nurses. A community based national early warning score (a system to respond when a patient showed clinical signs of deterioration) was being developed but had not yet been implemented.

### Staffing levels and caseload

- Managers and staff we spoke with said their caseloads were generally manageable. However staff shortages meant that many staff we spoke with told us they were working to the limit of their capacity. Staffing numbers in the community teams were based on the number of patients on the GP practices in the respective areas. We heard how teams managed to prioritise and risk assess in order to maintain a safe service. There was no staffing tool in place to determine staffing needs based on the dependency of patients. However when new cases were allocated team leaders explained how they took into consideration current caseloads and the level of individual experience. There were some teams where recruitment had proved more difficult, with one team, the Salisbury community team, being on the provider's risk register. Each weekday the community teams provided staffing numbers (actual verses what they should have) to the provider for the caseload rating tool. This worked out a rating based on colour. Caseloads were rated as green to black, with black being the highest rating for a caseload. A senior member of staff told us that teams would look to share the caseloads, and all patients would be reviewed to see if any could be moved if rated as red or black. Other actions if a service was rated as black included postponing training, and using bank staff.
- The Home First Service carried out daily audits on capacity and demand for monitoring purposes and to see if they were able to take on more patients. The service provided care and support to patients following discharge from hospital.
- Each community team had a shift coordinator in place and their role included assessing any patient visits that were referred to them. If the visit was urgent, they would assign a member of staff to visit the patient as they would know which member of staff had capacity to do this.
- The community teams had experienced a period of increased staff turnover between 1 January 2017 and 31 March 2017. The themes were due to relocation, staff wanting a better work and life balance, promotion, pursuing further education, and retirement. Some staff we spoke with commented that the recruitment process appeared slow at times. We spoke with team leaders who explained how they managed the workload during periods of staff shortage.
- The Salisbury community team was on the provider's risk register due to low staffing numbers. However, we found the team were well supported by senior managers during this period. Staff we spoke with commented on the outstanding commitment of their colleagues in the community team to maintaining the service for their patients. Staff had been flexible and proactive in organising visits and arranging support from other teams if possible, and in the use of bank staff. Despite being short staffed, the team had managed to further reduce referral to treatment times. We had very positive feedback from patients in the Salisbury area about the team and their reliability.

Good

# Are services safe?

## Managing anticipated risks

- The provider had a lone working policy, and there were processes to promote safety for staff while working in the community. Staff were able to tell us how it worked. There was a system to escalate concerns about the safety of a member of staff, and this would generate a manager's response, or if more serious, a 999 response.
- Community staff working on the evening shift told us they worked in pairs for safety if required. Staff confirmed the 'buddy' system they used made them feel safe if doing a visit on their way home. This was where staff phoned a designated area at one of the community hospitals depending on their location to confirm they got home safely. If they did not ring in, they felt reassured the escalation process would be implemented. A senior member of staff told us that a team leader was on call out of hours and they would be notified if a member of staff did not complete this process.
- A senior member of staff told us they had recently dealt with incidents of verbal abuse towards staff. This had resulted in two members of staff visiting the patient to make sure they were safe. They had also obtained advice from the safety officer who was due to visit the community team during our inspection. The purpose of this was to teach staff how to de-escalate the situation.
- In all locations we visited, first aid equipment was readily available, including emergency equipment and defibrillators. We saw that equipment had been regularly serviced. Clinics had emergency bells to call for assistance if required. In the outpatients' departments we visited, there were arrangements in place for staff to call for additional help in emergencies.
- In the event of extreme weather, the emergency preparedness plans included the provision of 4 x 4 vehicles to reach the most vulnerable patients. The plans included guidance on ensuring the most vulnerable patients were identified and prioritised, such as patients who needed daily medication.

## Major incident awareness and training

- The various services and teams had a business continuity plan in place. Plans were designed to prepare the service to cope with the effects of an emergency or crisis. The plans provided guidance about practicalities and safety. For example, there were instructions in the event of the loss of the use of building or power, as well as on the prioritising of services in the event of this becoming a necessity.

Good

# Are services effective?

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

## Summary

**We rated the effective domain as good overall because:**

- There was a holistic approach to assessing, planning and delivering care and treatment to patients. Relevant and current evidence-based guidance, best practice and legislation was used to develop how the services, care and treatment were delivered.
- We saw various examples where the latest National Institute for Health and Care Excellence guidance was being implemented.
- The service monitored patient outcomes and undertook a range of audits to promote best practice. Information was collected and available to the various teams. There was a clear approach to auditing and benchmarking the quality of the services provided and the outcomes for patients receiving care and treatment.
- Technology was used to enhance the delivery of effective care and treatment and was being positively embraced by community staff.
- We saw that staff worked together to assess and plan ongoing care and treatment when a patient was being considered for input from a different specialty or team
- Community teams responded quickly and effectively in response to end of life patients who were being discharged from an acute hospital.

## Detailed findings

### Evidence based care and treatment

- The use of innovative approaches to care and treatment in line with the latest best practice was actively encouraged. New evidence-based techniques and technologies were being used to support the delivery of high quality care
- We saw the service regularly reviewed and updated their policies to ensure they were in date and in line with the latest guidance. Relevant and current evidence-based guidance, best practice and legislation was used to develop how the services, care and treatment were delivered.
- We saw various examples were the latest NICE guidance was being implemented. NICE (The National Institute for Health and Care Excellence) provides authoritative, evidence-based guidance on the most effective way to diagnose, treat and prevent disease and ill health.
- The physiotherapy service was implementing the latest NICE guidance around the Lateral Step Up Test for Parkinson's sufferers. One staff member had attended training and then cascaded the guidance to their colleagues. In addition, after recognising there was a gap in the provision for treatment and assessment for vasovagal syncope episodes, the team had set up a course for staff to develop their skills in assessing and treating patients. Vasovagal syncope occurs when the part of your nervous system that regulates heart rate and blood pressure malfunctions in response to a trigger, such as the sight of blood.
- In line with NICE guidance, the provider had started an Early Supported Discharge Team, which had been in place since 1 April 1 2017. This was still in the development stage with some recruitment ongoing at the time of the inspection. In some areas the teams were already working, supporting and providing care for recently discharged patients. Staff supported the patients to work through exercises and guidance to develop their rehabilitation and sustain their recovery. As part of the process the team continued to assess the ongoing needs of the patients. An assessment was made on the medium to long term package of care required.
- Staff from the SALT (Speech and Language Therapy) service had recently completed a two-day training course on apraxia (a loss of the ability to carry out some movements). This had resulted in certain changes to practice that were shared throughout the team.
- The SALT team were offering LSVT (Lee Silverman Voice Treatment) to as many Parkinson's patients as they were able. LSVT is an effective speech treatment for individuals with Parkinson disease (PD) and other neurological conditions, however it is a resource heavy

and time intensive treatment that is not always available. The team were supported by the senior management in the development and provision of this therapy.

- The continence service organised three meetings a year for the nurses from the community teams who were designated as having a specialist interest in continence. This was used partly to promote the link between national policy and the local service. The manager of the service attended a southern counties continence forum; there is currently no national forum for continence services. This ensured the latest practices were being considered. For example, the service was developing the use of Biofeedback in managing female continence. Biofeedback has been proven effective in the treatment of urinary incontinence in numerous research studies. It can be used to help women learn to control and strengthen the pelvic floor muscles. The service was also working with reference to the NHS guidance in Excellence in Continence Care. The framework outlined a pathway including assessment, diagnosis and treatment to recovery where possible. An example being the "trial without catheter approach" pathway to continence care, which the team were introducing where possible.
- The tissue viability service provided regular training for the nurses in the community teams and had an internal target of training 35% of all the nurses in the teams. This learning was cascaded through the teams. They provided two full update days every year. This ensured staff were aware of the latest polices and any new initiatives that were being implemented. The service demonstrated outstanding processes of continuous improvement, through the analysis of results from incident investigations into identified pressure sores. This was done in conjunction with risk assessing of non-concordant patients in the community and the continuous improvement of reporting and documenting of pressure sores.
- We saw that the latest products and techniques for managing pressure care were being implemented and their effectiveness monitored. The service had produced information sheets and posters for all the community teams. The organisation was using an innovative type of pressure care treatment. This was an adjustable, wrap-around compression system made of breathable inelastic fabric. It is designed to be applied over conventional wound dressings, for the treatment of venous leg ulcers as an alternative to compression bandaging. The service had completed research into the effectiveness of this type of dressing and its cost effectiveness. The results from a study of sixteen patients had shown an 80% improvement in the quality of the healing rate. Following this, plans had been made for this type of treatment to be used across the whole service.
- Staff were trained to use the PURAT (pressure ulcer and risk assessment tool), which is a nationally recognised tool. The tissue viability team completed intentional rounding and provided all the community teams with skin bundles. Intentional rounding is a structured process where nurses carry out regular checks with individual patients at set intervals. The skin bundle was a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers. The object being to prompt consideration of all the health factors involved in maintaining skin integrity when planning care for a patient at risk of pressure damage. Nurses working in the community teams told us the support, guidance and professional advice from the tissue viability service was excellent.
- The clinical leads from the community teams met weekly with a consultant geriatrician from a local NHS acute trust. This gave staff the opportunity to discuss complex patients when required. They were also able to go directly to the consultant for urgent advice without going via the patient's GP. Local GPs had an open invitation to the weekly meetings.
- The respiratory service ran a programme called PACE (pulmonary advice and community exercise). This was a twice-weekly programme for patients, which ran for six weeks. The course included exercise as well as education, with a focus on "learning how to deal with exertion more positively." We spoke with patients who were attending this course, which was run at various locations around the county. We were told, "it's been great, if it was not for this I would not have got my confidence back" and another patient said, "I was so nervous to begin with but the staff have been brilliant, they are patient and really know how to motivate you."
- Staff were able to access all policies and procedures online. Under the agreement to establish Wiltshire Health and Care LLP, the workforce providing care on behalf of the organisation were employed by Great

Western Hospitals Foundation Trust (GWH). It had been agreed that staff followed the policies and procedures developed and approved by GWH. This was the case unless there was a specific policy required for community services that had been developed and then ratified by Wiltshire Health and Care's policies and procedures group. The group had been established to ensure the appropriate governance and monitoring arrangements were in place in relation to policies, procedures and competences.

- The electronic care record system had comprehensive care plans, which were easy to access. Staff were able to show us care goals relating to a range of simple and complex health and social care interventions. We also saw where staff had worked with patients to develop 'non-concordance care plans where patients had refused certain treatments or support.
- After completing training on transgender issues, staff had started using new psychosocial assessments for transgender patients. Staff told us these provided a more holistic approach to patients' needs and wishes.

### Pain relief

- When initial assessments were completed on patients receiving treatment from the community teams, an assessment of any pain relief was completed as part of the process. We spoke with patients who were receiving treatment for pressure ulcers, for example, who told us their pain was well managed.
- Patients who were receiving end of life care were supported with the appropriate pain relieving medicines through the use of syringe drivers, when required. Staff told us that this was provided very quickly when requested. Staff had completed the appropriate training to set up this equipment.

### Nutrition and hydration

- Patients care plans had assessments completed with regard to their nutrition and hydration needs. Staff used the MUST screening tool (Malnutrition Universal Screening Tool) and recorded the outcome in the patient's notes. Patients receiving treatment for wound care were given nutritional advice.

### Technology and telemedicine

- Technology was used to enhance the delivery of effective care and treatment, and was being positively embraced by community staff. This was of particular benefit due to the size of the area the services covered, and the extensive travelling times that some staff were required to complete. Mobile working and use of electronic information had improved service delivery. For example, community nurses used a triage system to allocate work and monitor progress through the day. We saw a triage nurse using the system to monitor staff progress, workload, and allocate work based on risk assessments.
- Community nurses who had been suitably trained were starting to use mobile ECG technology for patients in their own homes. ECG or Electrocardiography is the process of recording the electrical activity of the heart. The latest software enabled the nurse to transfer the data directly onto their mobile devices, and then submit this directly into a patient's record and to another health professional. A nurse described a recent example of this, which had meant a patient with mobility problems had been saved a difficult journey at the weekend, which would have taken up half of the day.
- Nurses could use the mobile devices to upload photographs of pressure ulcers for reference and advice remotely. This meant staff saved time, and a patient could receive treatment quicker.
- The community services were developing the use of FLO texting (Florence) to help achieve better outcomes by promoting self-management. FLO texting is a system that allows communication between clinicians and patients using text messaging to achieve better and faster health outcomes. Staff told us this was helping with therapeutic engagement and outcomes for patients by improving the efficiency and reliability of communication

### Patient outcomes

- Staff were actively engaged in activities to monitor and improve quality and outcomes and participate in benchmarking, peer review, and research.
- The service monitored patient outcomes and undertook a range of audits to promote best practice. Information was collected and available to the various teams. There was a clear approach to auditing and benchmarking the quality of the services provided and the outcomes for patients receiving care and treatment. The provider used an electronic performance management system, which was used to produce performance and dashboards for each individual community team and each specialised service.

Good

# Are services effective?

- Information about patient's care and treatment was routinely collected and monitored. Information showed that intended outcomes were being achieved for patients who used services.
- The speech and language therapy service were using the Royal College of Speech and Language Therapy Outcome Measure (TOM). TOMs are an outcome measure that allows professionals from many disciplines working in health, social care and education to describe the relative abilities and difficulties of a patient/client in the four domains of 'impairment', 'activity', 'participation' and 'wellbeing' in order to monitor changes over time.
- The provider participated in local and national audits, benchmarking, accreditation, peer review, research and trials. For example:
  - Wheelchair service pathway audit (a re-audit).
  - Non-medical prescribing practice and competence audit.
  - National stroke audit (2016/17).
  - Evaluation of the malnutrition universal screening tool 'MUST' and care planning in South Wiltshire care homes (second re-audit).
  - Infection and prevention & control care bundle audit.
  - Resuscitation audit 2016.
- The physiotherapy teams were collecting Patient Reported Outcome Measures (PROMS) data to audit outcomes for patients. PROMS assessed the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMS calculated the health gains after surgical treatment using pre- and post-operative surveys. They were using the latest EQ5D systems of auditing. EQ5D is a standardised measure of health status developed in order to provide a simple, generic measure of health for clinical and economic appraisal. Applicable to a wide range of health conditions and treatments, it provides a simple descriptive profile and a single index value for health status that can be used in the clinical and economic evaluation of healthcare as well as in population health surveys. The service was also implementing the latest NICE musculoskeletal pathway for patients.
- The tissue viability service audited every pressure wound that was reported onto the electronic patient records. The administrator for the team checked through every case to see that the notes had been updated and that all pressure wounds had been correctly reported. This helped ensure that investigations were completed and followed up when necessary.
- The respiratory team contributed data to the national Chronic Obstructive Pulmonary Disease (COPD) audit programme.
- As part of NHS England's national Commissioning for Quality and Innovation (CQUIN) programme 2017/18, the organisation was working towards five targets for community services to improve care. These included supporting proactive and safe discharges, improving the assessment of wounds, and personalised care and support planning. The CQUIN scheme was intended to deliver clinical quality improvements, and drive transformational change. At the time of this inspection, the provider was working towards these and monitoring their progress.
- The diabetes service ran education courses for patients. There were courses for patients diagnosed with type one and type two diabetes. "Freedom for Life" was an "intensive education" course run by a dietitian and a diabetes specialist nurse. Groups were for a maximum of six people, and patients were invited to bring a friend if they wished for support. The local "X-PERT" programme was a six-week group diabetes education programme for patients with type two diabetes. This aimed to help patients learn all about the up-to-date treatments and management of their condition. They were also able to explore and address problems/issues that they may have with their diabetes. The purpose of these courses was to enable patients to manage their own diabetes in the future with minimal input from professionals. We spoke with a patient who had attended one of the courses and they described it as an excellent service, which had really helped them to feel more confident about managing their illness.

### Competent staff

- Staff had the right qualifications, experience and knowledge to undertake their roles, and were supported to undertaken further training. Staff were supported to acquire new skills and share best practice. Competence and knowledge was recognised as being integral to ensuring high quality care.
- Staff were regularly supervised and appraised by their managers and all staff we spoke with were positive

about the quality of support from line managers. We heard that staff felt supported by other team members, that good practice ideas were shared, and advice could always be found.

- The service had well qualified staff working as managers for the specialist services. For example, the tissue viability service and the respiratory service for patients with complex chronic lung diseases had senior nurses leading the teams with extensive qualifications in their specialised fields. Staff working in the community teams were positive about the expert advice and support that was available from all the leads of the specialist services.
- There were arrangements for supporting and managing staff included appraisals, training and supervision. Training and supervision was a mixture of one-to-one meetings, coaching and mentoring, clinical supervision and revalidation. However, formal recorded supervision was primarily management focused. Nurses, therapists and other health professionals described clinical supervision as more informal and infrequent. There was a supervision policy, however application was inconsistent. This was partly due to some staff being supervised by a manager from a different profession. This could lead to them needing to see another professional for clinical supervision, which occurred regularly. This did not always happen with the required frequency.
- All staff we spoke with said they felt well supported and received regular supervision either through meetings or in one to one sessions. However, we found among some staff there was a degree of confusion around clinical supervision and the meaning of this. Some staff told us they had clinical supervision frequently alongside their normal supervision, where other staff were not quite sure of the difference.
- Community nurses told us they had to complete a number of competences in their role before they could undertake certain tasks. For example, setting up syringe drivers and applying compression bandaging on leg ulcers.
- Assistant practitioners (band 4 healthcare assistants with additional training) were able to take on additional tasks once training and competencies had been completed. For example, urethral catheterisation, insulin injections and compression bandaging.
- The staff working for the 'Home First' service were provided with a number of training topics to help them meet the needs of the patients they visited. This included, for example, nutrition and medication (as they prompt patients with these areas).
- Staff were receiving regular appraisals, though at times staff shortages had meant this did not always meet targets. However, where this had happened, action plans had been developed to address this. For example, in the Amesbury community team where this had been a problem. The provider's workforce and development monthly report from January 2017 defined the appraisal target as 90%. The community adults' service had achieved 85.7% in January 2017 with a 12-month average of 83.3%. The community specialist services had achieved 86.4% in January 2017 with a 12-month average 86.7%. The overall trend for appraisal was improving with a focus on teams that needed support to improve further. During the inspection, we noted, for example, by 1 April 2017, six teams were at 90% or above. The Marlborough community team and the wheelchair services were both at 100%.
- Staff learning needs were identified during appraisal and some supervision and training was appropriate to meet their learning needs. Staff told us they were encouraged and given opportunities for development. We also saw examples of how staff had been supported through appraisal and supervision when performance of key tasks was poor or variable.
- Community nursing teams had 'link nurses' who attended meetings for certain specialities. This included, for example, tissue viability as a specialty. Information from these meetings was shared by the link nurses with the rest of their teams at their meetings.
- Staff were positive about the availability and quality of in-house training, though some staff shortages had restricted some opportunities. The heads of various specialties had organised training that encouraged multidisciplinary working and understanding. The tissue viability service provided regular training opportunities for the community teams, which helped ensure they were competent, confident, and up to date with the latest guidance and products. The physiotherapy service had organised a motor neurone study day. The day involved physiotherapist, dietetics, wheelchair services, and health and social care staff.
- There were development opportunities for staff. Staff we spoke with said the provider supported people to

progress when this was possible through internal training and promotions. For example, band three health care assistants could train as assistant practitioners (moving up to band four) and band six nurses could have opportunities to train as clinical leads. Management and leadership training modules were available too.

- The physiotherapy team had appointed a band seven respiratory clinical lead who was able to provide oximetry home lung function tests. Prior to this appointment, patients would have to have attended the acute hospital.
- Within the specialist continence team, each nurse had their own area which they championed and shared their knowledge with the rest of the team. For example, this included a link with a Prostatectomy clinic run at a local acute hospital. Prostatectomy is a medical term for the surgical removal of all or part of the prostate gland. This operation is done for benign conditions that cause urinary retention, as well as for prostate cancer and other cancers of the pelvis. Another nurse had a responsibility for looking at ways of improving the overall care pathway for patients.
- Some services provided care and treatment to children, for example the continence and podiatry teams. The continence team had a nurse who specialised in children's treatment and patients were referred to these clinics by other teams. Staff were clear about the boundaries of treatment and when a referral needed to be made a specialised childrens service. For example, the physiotherapist would treat children over the age of five but only those on a musculoskeletal pathway. If a child had a developmental condition they would be referred to the specialist childrens physiotherapy service.
- We had positive feedback from patients and their relatives about the competency and approach of all the health professional providing care and treatment. Comments included "I have complete and total confidence in the nurses", "If I'm not sure about anything I ask and they always explain everything to me", "They are not afraid to try different things to help him" and "They know what they are doing."
- Each community team had a clinical lead and a team leader and all staff we spoke with were positive about the quality of support and advice that these staff provided.

### Multidisciplinary working and coordinated care pathways

- Staff within teams and across different services were committed to working collaboratively and developing ways of working that delivered effective and high quality care. Staff from different teams and specialist services were positive about their colleagues and the joined up working they were involved in delivering.
- We observed and saw evidence of various examples of exceptional multidisciplinary working. All staff, including those in different teams and services, could be involved in assessing, planning and delivering patient care and treatment. Staff spoke positively about the cooperation and communication with different colleagues and how information was shared to benefit patient care support and treatment.
- We observed three multidisciplinary meetings during the inspection. Staff shared information about patients' needs to promote consistency of care and keep patients with clinicians they were familiar with. Emotional, physical and social needs were considered and the patient preference for therapy. The impact on the patient of treatment and therapy was discussed and what was important to the patient.
- We spoke with a care coordinator who was employed by the provider. They told us their role was non-clinical and they helped to reduce social isolation and unplanned admissions. They worked with GP's hospitals and other community services. They were involved in, for example, planning for hospital discharge for patients who were assessed as being at risk.
- A senior member of staff from one of the community teams told us they had designated days when they visited care homes. A nurse was assigned as a lead for each care home to improve communication between the team and the care home and also give the home staff a point of contact.
- Community staff told us they worked closely with the local hospice when caring for end of life patients. The hospice clinical nurse specialists attended weekly meetings with community teams where patients' care was reviewed. They were also able to arrange joint home visits.
- Care coordination for patients with both routine and complex needs worked well. This was due to patient

information being available on mobile electronic devices. Community nurses and other professionals could also refer to other specialists directly from a patient's home, which increased referral efficiency.
- There were regular meetings, which included clinical leads, support workers, therapists, nurses, students and administrative staff. We attended a neurology service triage meeting. These were held fortnightly, and attended by physiotherapists, occupational therapists and community nurses. We saw patients were reviewed, information shared, and joint visits arranged.

### Referral, transfer, discharge and transition

- There was a holistic approach to planning people's discharge or transfer to other services, with arrangements reflecting personal choice and circumstances.
- Staff worked together to assess and plan ongoing care and treatment when a patient was needed input from a different specialty or team. Staff had a good links with their colleagues in the community hospital inpatient services, and with professionals such as discharge coordinators in the acute hospitals they worked with. There were clear lines of communication in place. There was a single point of access for the public to contact for information or to make a referral. This service was managed for Wiltshire Health and Care by another provider under a pre-arranged agreement. Wiltshire Health and Care had access to the same electronic record system, and staff and managers we spoke with thought the referral process was working effectively. Patients we spoke with told us the referral process was clear and efficient.
- Community teams responded quickly and effectively in response to patients at the end of their life who were being discharged from an acute hospital setting. There were strong links with local palliative care networks that helped provide a joined-up service for end of life patients who wished to spend their final days in their own home. Several staff we spoke with commented this was an aspect of the community service they were most proud of. We had feedback from bereaved relatives who told us that the teams "had gone beyond what we expected" and another described the support with making arrangements and said, "the staff were just great with all of the family, nothing was too much trouble." We heard how different services worked together to coordinate the care and support patients needed at home. This included quickly arranging any adaptations that would make the final days at home more comfortable for patients.
- Wiltshire Health and Care had been established for just under twelve months when we inspected. Managers and front line staff we spoke with felt that this had led to improvements in the working relationships with the NHS acute trusts that staff and patients linked in with. There were formal meetings around different specialties and informal contact around individual patients. For example, the continence service jointly ran a one-stop clinic at a local NHS acute hospital and attended multidisciplinary meetings with maternity services and the colorectal team. A major aim of this joint working was to discuss what support was available to patients in the community and to help avoid surgery if possible.
- There was a single point of access for professionals and other clinicians to make referrals; this service is contracted separately by Wiltshire CCG with another provider. The single point of access was managed through an agreement with an NHS provider, and staff we spoke with said this worked well. Teams could receive referrals from GPs, other health professionals in other teams, and from NHS acute services. Patients we spoke with in general said that services and staff were easy to contact and responded quickly to requests for information about appointments.
- We observed how teams triaged new referrals and saw this was effective and prompt. For example, we saw a physiotherapy team triaged daily an average of 10 referrals. They would often phone the patient to clarify specific details and to determine the urgency. GPs would contact the service about patients on the waiting list who had deteriorated and they would be seen more urgently. The teams were seeing all patients within the recommended referral to treatment times and would prioritise the patients according to need.
- A senior staff member for the Chippenham and Corsham team told us they had a shift coordinator who would review any new referrals made to the team. If they were urgent they would assign a member of staff to visit the patient as soon as possible.
- 'Home first' was a discharge from hospital scheme, which used a structured and standardised process. This had been recently introduced and it aimed to reduce the number of agencies involved in the process, and reduce the number of multiple referrals and associated

risks. A full assessment in the person's own home at the point of discharge aimed to establish a rehabilitation programme. Patients and their carers were to be supported at home by one service (the Community team) in their first days at home. Community team staff would arrange a managed transfer of care (if required) to the appropriate home care agency within 10 days of the patient's discharge from hospital. The delivery of rehabilitation programmes were planned to improve patient outcomes and reduce the number of patients requiring ongoing packages of care.

- The neuro physiotherapy service had formed an early supported discharge team in line with the latest National Institute for Health and Care Excellent guidance. This team had been launched on 1 April 2017 with the aim of providing an initial six weeks of support to patients after discharge from hospital. This was designed to reduce the pressure on the community teams and contribute to more discharges for medically fit patients. It was too early for detailed auditing but staff we spoke with felt the service was developing and having a positive impact.

### Access to information

- Information and records systems supported the delivery of effective care and treatment. Staff mainly used electronic systems to manage care records and information was easily coordinated to support delivery of effective care.
- Staff we spoke with said they had all the information needed to plan and deliver care and treatment. They were also able to share information on behalf of patients and carers appropriately with relevant staff in a timely and accessible way.
- Staff were nearly always able to access care records when working remotely and visiting patients' homes. The system would update both the workers mobile device and the centrally held record when workers who were out of range or in a poor signal area returned within range of equipment. For example, in the hand therapy outpatient clinic, staff had computer access to details of the referrals to their clinic and follow up letters and any other relevant information from the NHS acute trust.
- Community nurses told us in the Chippenham area they had access to all but three GP practices' computer systems. This meant they were able to have up to date information about their patients as well as sharing their information with GPs.

### Consent, Mental Capacity act and Deprivation of Liberty

- Consent to care and treatment was sought in line with legislation and guidance. Staff were aware of the need to ask for consent and for this to be appropriately recorded. We saw patient records and treatment plans where consent was clearly recorded. Staff we spoke with understood the relevant consent and decision-making requirements of the Mental Capacity Act 2005. Staff assumed consent unless they felt during assessment that a patient lacked the mental capacity to consent to that care or treatment.
- Staff gave examples of what they would do if they had doubts about a patient's capacity. This included reviewing the patient with other professionals, speaking with a patient's family members to understand personal wishes, and talking with the patient's GP. If a patient were assessed as not having capacity, staff would act in their best interests of that patient with any care and treatment decisions.
- We observed patients both at home visits and at outpatient's appointments being asked for consent by staff to treat them.

Outstanding ☆

# Are services caring?

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

## Summary

**We rated the caring domain as outstanding overall because**:

- Staff took the time to interact with patients and their families who used their services in a respectful and considerate manner. Feedback we received from patients was overwhelmingly and universally positive about the compassionate approach from the community staff. Patients thought the staff went the extra mile and the care often exceeded their expectations. We received these positive comments about community staff working in all the various settings and different teams.
- Staff spoke about their admiration for the commitment to high quality and compassionate care provided by their colleagues throughout the various teams and professions.
- Staff communicated with patients and their relatives so that they understood their care and treatment. Staff were motivated and inspired to offer care that was kind and promoted people's dignity. Patients and their family/carers were included in the discussions about their care and treatment.
- Patients in their homes and at outpatient departments were given full and detailed explanations of their care and treatment.

## Detailed findings

### Compassionate care

- Staff took the time to interact with patients and their families who used their services in a respectful and considerate manner. Feedback we received from patients was universally positive about the compassionate approach from the community adults' staff. Patients thought the staff went the extra mile and the care often exceeded their expectations. This included all the different specialties who worked with patients.
- We spoke with 51 patients and relatives in total and all told us the staff treated them or their families very well. All praised the staff for the work they did. We were told the staff were "caring and compassionate, respectful and professional."
- The mother of a patient who had special needs always accompanied them to appointments and told us "the staff really take their time when seeing [the patient] and put [the patient] at her ease."
- An elderly person receiving a service from the community nurse told us "she said I could ring any time, I cannot fault her treatment and the way she listened to me."
- A selection of other comments included, "we both find them caring and helpful", "we asked for weekend visits to stop so we can have some more private time together, they understood this", "I feel I'm looked after very well. They listen to me and they listen to my wife", "I can't speak highly enough of them they are fantastic", "everyone at the continence clinic is so approachable including the receptionist", and "the nurse went above and beyond my expectations, she picked me up and helped me when I most needed it." Several patients commented of the community teams that, "nothing has been too much trouble for them."
- In all the outpatient clinics, we observed we received very positive feedback about the staff. For example, "the member of staff was excellent. I always liked to see them as I know them and they know my issues."
- In outpatient clinics, we observed staff supporting patients who were upset and allowing them time to express their concerns.

### Understanding and involvement of patients and those close to them

- Staff were motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between patients who used the service and staff were strong, caring and supportive.
- Patients and their family/carers were included in the discussions about their care and treatment. We observed patients in their homes and at outpatients' departments were given full and detailed explanations of their care and treatment. Staff communicated with patients and their relatives so that they understood their care and treatment.

Outstanding ☆

# Are services caring?

- Patient's relatives/carers, where appropriate, and care workers in a residential care homes, were also given detailed guidance and instruction regarding the care required.
- Patients were included in their care and treatment and given time to discuss any concerns or queries they had. Staff checked the patient understood in a discreet manner and explained aspects of care again if needed.
- Patients confirmed they were involved in their care and treatment and their relative/carer with their consent. Staff asked them for their views and offered them choices about their treatment if able. Patients and their relatives/carers said they were able to ask questions if they were unsure about anything. A patient's relative told us "the staff are very genuine and I know they will see me through this difficult time."
- One person spoke about nurses who they have not met before. They said, "new nurses are always introduced to us and accompany a regular nurse at first."
- Another person said "they are very good when they have a new nurse on the team. They bring her to meet me and show her what they do. So, the next time they send the new nurse she is used to me and me her."

### Emotional support

- Staff recognised and supported the broader emotional wellbeing of patients and their families.
- Patients receiving end of life care were provided with emotional support from the community teams and were signposted to other services such as local hospices and charities. Staff continued to offer bereavement support for families for a period of time if this was required. Feedback we received from patients included comments about the "brilliant support" and the "wonderful care" shown "for all the family" through the period of bereavement.
- Patients receiving treatment from the specialist therapy teams told us how they were empowered and supported to maintain as much independence as possible. One patient who had attended a class run by the respiratory team to manage their condition told us, "they have really helped me to gain my confidence by the encouragement they give everyone."
- A member of the speech and language team had supported a patient with cancer to access a charity to provide counselling support after they were unable to access IAPT within a reasonable amount of time. IAPT (Improving Access to Psychological Therapies) is a national programme to increase the availability of counselling or 'talking therapies' on the NHS. It is primarily for people who have mild to moderate mental health difficulties, such as depression, often following the diagnosis of serious illness.

Outstanding ☆

# Are services responsive to people's needs?

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

## Summary

**We rated the responsive domain as outstanding overall because:**

- The organisation had a clear programme and plan for the delivery of community services. The services were flexible, provided choice and ensured continuity of care for patients.
- There was evidence of excellent work with local services to promote better care and treatment and help prevent hospital admission.
- Community staff working at weekends were supported by an administrative team that also worked weekends as part of their scheduled hours.
- Services were appropriate to the local needs of the local population and all services were within national referral to treatment time (RTT) targets for first appointments. Service managers had been proactive in improving the RTT times for certain services.
- Urgent appointments were clearly identified and arranged when required by all services. Community teams and specialist services had protocols for dealing with urgent referrals.
- The service was very responsive to meeting the preferred needs of patients at the end of their life.
- The service received few formal complaints. Patients who used the service knew how to make a complaint or raise concerns, and were encouraged to do so. We saw that complaints were handled effectively and confidentially, with regular updates and a formal record kept.

## Detailed findings

### Planning and delivering services which meet people's needs

- Services were planned and delivered to meet the needs of patients in their own homes where possible. Wiltshire Health and Care LLP had been established in July 2016 with a clear programme and plan for the delivery of community services.
- Information about patients' needs was used to plan and deliver services. Where patients' needs were not being met as efficiently as staff and patients would like, for instance for hospital discharge, this was identified. The information was used for service planning. For example, the developments such as 'home first' and the early supported discharge scheme. There was a focus in a number of plans on avoiding hospital admission for patients where possible, and supporting the early discharge of patients in responsive and innovative ways. This was recognised as the best outcome for patients and also to have a positive impact on the availability of inpatient beds in the community hospitals.
- There were four community focused projects and one that was organisation wide with supporting strategies:
  - Health coaching - training in health coaching techniques to community clinicians.
  - Musculo-skeletal physiotherapy - Increased availability of physiotherapy assessment and treatment in the community.
  - Stroke early supported discharge (ESD) musculoskeletal condition - Development of an ESD service for Wiltshire, run from two hubs (North and South).
  - Mobile working - making full use of hardware, software and redesigning administrative processes to support a more mobile workforce (there was also an information technology strategy planned to be developed during 2017).
  - High Intensity Care (HIC) - increasing the capacity and capability of multidisciplinary teams, community geriatricians, other specialists and general nursing to offer a higher intensity of care to patients at home.
- Work was undertaken to shape, plan and then support the delivery of these projects. For example, the high intensity care service had five main themes of development:
  - The development of the pathway.
  - The development of HIC multidisciplinary teams with community geriatricians.
  - Ambulatory care provision in community wards.
  - Review of the medical cover on community wards.
  - Amendments to electronic records systems so that GPs could access information about who was receiving the service and could contribute to the HIC multidisciplinary team if they were not able to attend in person or by phone.

# Are services responsive to people's needs?

- There was evidence of excellent work being done with local services to promote better care and treatment and help prevent hospital admission. For example, the specialist tissue viability team provided training for nurses in care homes and also to staff in some domiciliary care agencies. This process of 'training the trainers' could provide better care in the community for patients and also help with avoiding hospital admission. The continence service had provided a basic level continence assessment for care homes to use, which they could complete and send to Wiltshire Health and Care staff for advice. They also provided training four times a year for care home staff to promote their understanding of continence management generally, as well as how to complete the assessments.
- The provider had recently introduced the 'Home First' service. This service worked closely with the local NHS acute trusts improve the time it took to discharge patients home. The organisation had links with other home service providers to provide a joined-up service. There was a screening process to make sure patients were suitable for the service. When patients came home, band four health support workers with rehabilitation experience supported them in their own home. The assessment and rehabilitation period was planned to be from seven to 10 days, but patients were able to remain on the caseload longer if necessary.
- Services provided, such as the wheelchair service, the tissue viability, lymphoedema service, and the respiratory nurse service reflected patients' needs and ensured flexibility, choice and continuity of care.
- The physiotherapy service ran a group called "BeFit" which was a falls and balance group for people recovering from having had a fall. The group met in different locations in the community to minimise the travelling for patients who had mobility problems. It was a six-week programme, after which patients were reassessed to see if they needed to attend a further course. After finishing the course, patients were telephoned after six and twelve months to see how they were progressing.
- The outpatient services were provided in areas that were well maintained and comfortable. Areas were well signposted and the clinics being run were clearly displayed.
- Specialist teams took a flexible approach to meeting patients were this was possible. While clinics were held in the community hospitals, services also used many other locations to help with patients' transport and mobility. Staff could book rooms in various health centres or GP surgeries to help access for patients. If patients preferred home visits, these were arranged where possible.
- Community staff working at weekends were supported by an administrative team that worked weekends as part of their scheduled hours. This helped with the delivery of services and supported good communication between the different services.
- The specialist teams had produced various information leaflets about the services they provided and also individual brochures for any specialist courses they ran for patients. These were all clearly written and up to date. We had positive feedback from patients that information was presented clearly and informatively.

### Equality and diversity

- Services took account of the needs of different patients, including those in vulnerable circumstances. Services were planned to take account of needs of different patients on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation. Staff we spoke with were aware of the cultural diversity of the areas they worked in and were able to describe how this influenced their practice to ensure they were sensitive to people's needs.
- The provider was taking action to promote equality and tackle discrimination. There was an action plan for the Equality and Diversity Vision 2014 – 2018 (29 March 2017) which was reviewed by the board and senior management team. This had been produced by the NHS trust that previously ran this service, and adopted by Wiltshire Health and Care with approval. It had comprehensive 'milestone actions' recorded and comments on the progress around equity and fairness in access to services.
- The objective was for services and opportunities to be as accessible as possible, to as many patients as possible, at the first attempt. There were four stated equality and diversity objectives;
  - Better health outcomes for all.
  - Improved patient access and experience.
  - Empowered, engaged and included staff.
  - Inclusive leadership at all levels.

# Are services responsive to people's needs?

- The provider planned to build up data relating to equality and diversity to support the achievement of the outcomes and help to eliminate discrimination, advance equality of opportunity and foster good relationships.
- A number of staff had completed a course on transgender issues. This had resulted in changes being made around terminology in the information pack that was available to staff and patients.
- The provider had made arrangements for staff to access translation services, which could be delivered in person and by telephone. All information and leaflets could be translated into different languages for families from ethnic backgrounds.
- The speech and language service had developed a number of resources and ensured there were opportunities for patients with language and cognitive difficulties to engage in decision making around their care and treatment. We had feedback from one parent and a carer who explained how the service had taken the time to ensure that the patient's treatment was understood and consented to by the patient. Some members of the team had also learnt some basic phrases in different languages to use to support patient understanding. These would be used as well as the translation services.

### Meeting the needs of people in vulnerable circumstances

- Patients who were assessed as being at risk or who had pressure ulcers were provided with an information leaflet about how reduce risks and improve the healing of their pressure ulcer.
- Community staff had completed training in dementia awareness. Several staff we spoke with explained how they managed and responded to patients who may be confused or anxious due to their illness. We heard how staff would support people with learning difficulties. One therapist explained how they would see a person on their own but would always ask if they would prefer someone to be there to support them. One therapist described how after treating a patient she asked whether they would be happy for their parent to come into the room while they explained the future course of treatment. This happened with their consent.

### Access to the right care at the right time

- Patients had access to timely assessment, diagnosis and treatment. Patients were able to access services in a timely way for assessment and treatment. Services were appropriate to the needs of the local population, and all services were within national referral to treatment time (RTT) targets of 18 weeks for first appointments.
- The provider performed well against the national RTT timescales. For example:
  - Adult and child continence - 10 and 16 weeks.
  - Diabetes, lymphoedema, outpatient physiotherapy, speech and language therapy - three weeks.
  - Dietetics and podiatry - five weeks.
  - Community Teams - one week.
  - Neuro specialists 10 weeks.
  - Pulmonary rehabilitation - four weeks.
  - Wheelchair service - seven weeks.
  - Tissue Viability within one week.
- Over the six months prior to our inspection visit, the continence service had taken steps to reduce their waiting times, which had been above the 18-week target. The service had achieved this by improved data collection, the increased use of telephone follow up consultations with patients, and the restructuring of certain clinic arrangements. The service also proactively moved patients up the waiting list when appointments were cancelled. The service was also able to respond to all urgent referrals within seven days.
- Community teams and specialist services had protocols for dealing with urgent referrals. These would be triaged and then allocated in the team. Team leaders played a role in identifying and allocating these. We saw examples of how the staff responded to prioritise urgent needs for patients within the wheelchair, continence and podiatry services. For example, a patient told us, "Two days after coming out of hospital I felt really unwell and thought I might have a urinary infection. I couldn't get and appointment with the GP that day and rang the clinic. [The nurse] was fantastic, she saw me and took samples and wound swabs. She rang the GP who then rang me back and wrote a prescription for antibiotics."
- We spoke with staff at one of the care homes we visited with the community nursing team. They told us whenever they contacted the community nursing service they always visited promptly.

# Are services responsive to people's needs?

- A self-referral system was being considered for some physiotherapy clinics and this process was being considered for expansion. This would be where patients would be able to book their own appointment, within a designated time frame.
- The feedback we received from patients about community nurse visits was variable, in that they did not always know when they were visiting. Some patients felt this was acceptable, however on one visit a patient told us they needed to know when the nurses were visiting. The nurse said to the patient they would try to give them a time slot and ring them before they next visited.
- Staff told us they were looking at ways of reducing their 'did not attend' (DNA) rates for outpatient clinics and 'no access visits' for community nurses. 'No access' was when a nurse visited a patient but was not able to get into the property or the patient was not there. In May 2017, for example, one physiotherapy clinic had 44 patients who did not attend for their appointment. They were planning to start using the text service to remind patients of their appointment times. For community nursing teams, senior staff told us they were encouraging staff to review patients to see if they could access other services and to start the conversations with patients if they were able at the first visit.
- Service managers told us they were sent a weekly e-mail with the latest figures of their waiting list. They were also able to monitor this electronically at any time.
- All the outpatient services we visited told us patients were seen within the 18-week target. Urgent patients were seen more quickly. For the hand therapy service, staff told us patients were seen quickly due to the type of treatment they required which needed to be delivered promptly. This was maintained due often to the goodwill of the staff working there.
- We observed a patient having treatment in the orthotics outpatient clinic. They told us they had to wait a long time to get a follow up appointment as they were having issues with the equipment they needed. However, they told us they were happy with the outcome of their appointment. We spoke to a senior member of staff who confirmed that follow up appointments were always difficult to fit in due to limited clinics.
- All the community teams provided a high standard of care and support to patients at the end of their life. The service monitored the number of patients they were supporting across the county, and recorded the number who had advanced care plans in place. The latest figures from the provider showed that 94% of patients were able to be in their preferred place of care for their final days. Within the individual teams, there were nurses with a specialist interest in end of life care. They shared practice issues and developments with other staff. The teams could provide ongoing support to families with the bereavement process for a period of several months. The manager for end of life care had links with local groups and also other support groups across the south west. We received feedback from relatives who told us about the "brilliant care" that had been provided and how staff had gone "beyond what we expected." We also saw a sample of compliments the organisation had received from families praising the care and commitment of the nursing and support staff.
- Several staff from the community teams told us that the end of life care provided was the thing they were most proud of. Staff told us they were supported and led in this work by managers who were very committed to providing the best possible service to patients and their families.
- The continence service provided a fast-track service for end of life patients. Following a community assessment, they ensured that the things the patient needed were delivered within 24 hours.
- At all the outpatient clinics we visited, we saw that the appointments were running on time. Staff explained that if they were running late for any reason then they keep patients informed. Feedback we received from patients told us that the clinics were well organised and generally ran on time.

### Learning from complaints and concerns

- Patients who used the service knew how to make a complaint or raise concerns, and were encouraged to do so. We saw that complaints were handled effectively and confidentially, with regular updates and a formal record kept. At the locations we visited, we saw that information was displayed about the complaints process available to patients. Information was also displayed on the provider's website. The service had received few formal complaints
- Patients' concerns and complaints were listened and responded to and used to improve the quality of care. For example, in the podiatry service, patients had identified an issue with communication. The service

introduced an additional means of communication to help patients contact them using telephone and email. On another occasion, additional teaching was provided to improve professionals' practice in a clinic.

- In the hand therapy outpatient service, staff told us about changes that had been made following a complaint. This has resulted in protected time to review all new referrals and to arrange clinic appointments for them.
- Some patients who had complained had taken the opportunity to meet with staff face to face. This reassured them that the provider was following both its own and professional guidelines and codes of conduct both during practice, and when dealing with complaints.
- The outcome of complaints had been explained appropriately to patients, and we saw evidence of openness and transparency about how complaints and concerns were dealt with.

Outstanding ☆

# Are services well-led?

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

## Summary

**We rated the well led domain overall as outstanding because:**

- A strategy was outlined in a delivery plan and included a five-year programme of change needed to support the vision. The business plan for 2017/18 included the focus on adult community services, strategic organisational development, delivery structure and financial planning, including investment policies.
- The governance framework ensured that responsibilities were clear and quality, performance and risks were understood and managed. Staff were clear about their roles and understood what they were accountable for.
- There was a programme of clinical and internal audit, which was used to monitor quality and systems, and identify where action should be taken.
- Services were provided with outstanding leadership in the community teams and specialist services. Good and effective leadership was also provided by the heads of service, the senior managers and from the board.
- We found there was a positive and motivated culture within the various teams. Staff expressed pride at the quality of service delivered and the care and treatment patients were afforded. All staff we spoke with were positive about the organisation and felt engaged with the development of the services that were being provided.
- The provider had consulted with staff to produce organisational values.
- Managers and frontline staff were encouraged and supported to be innovative and continuously improve service were possible.

## Detailed findings

### Leadership of this service

- The community adults' services were provided with good leadership. We found evidence of this in the local community teams and the specialist services. Good and effective leadership was also provided by the heads of service, the senior managers and from the board. The majority of staff we spoke with told us their managers and the board members were visible, accessible and responsive.
- Several staff spoke very positively about the leadership from the community team area managers. Staff were also very positive about the leadership of the specialist services. For example, we were told how the tissue viability service responded quickly to requests for support and advice. They gave community teams great leadership in developing and improving the care they provided in relation to pressure care treatment and prevention.
- Staff we spoke with from the community and specialist therapy teams told us they believed the senior managers in the new organisation of Wiltshire Health and Care had an improved understanding of community services. We were told this was reflected in their communication with staff and the responsiveness to issues the community staff raised.

### Service vision and strategy

- There was a clear vision and strategy to deliver services to the community with quality and safety as priorities.
- The vision was to enable patients to live independent and fulfilling lives for as long as possible. This was to be achieved through collaborative working, ensuring home and community care was always the first option, seeing the whole person, using technology, teamwork and trust.
- A strategy was outlined in a delivery plan and included a five-year programme of change needed to support the vision. The business plan for 2017/18 included the focus on adult community services, strategic organisational development, delivery structure and financial planning, including investment policies. The plan included future workforce modelling, long-term financial strategy and more effective integration.
- The organisation had begun implementing three new services, the Home First Service, the High Intensity care scheme and the Early Stroke Discharge team. These services were aimed at improving care and treatment or patients either through admission avoidance or

subsequent quicker discharge from hospital. Support on discharge, with intensive input around rehabilitation and assessment, helped promote independence and recovery.
- Progress against delivering the strategy was monitored and reviewed at board and service level.

### Governance, risk management and quality measurement

- The governance framework ensured that responsibilities were clear, and quality, performance and risks were understood and managed. Staff were clear about their roles and understood what they were accountable for. The governance framework supported the delivery of strategy and good quality care.
- There was a process for systematically seeking and providing assurance both up and down and across the organisation. Comprehensive performance measures, which were reported, monitored and actions being taken to improve. There was a programme of clinical and internal audit, which was used to monitor quality and systems, identifying where action should be taken.
- There was a holistic understanding of performance, which integrated the views of the patient, with safety, quality and financial information. The information was used to monitor and manage quality and performance and was accurate, timely and relevant. We saw team leaders and others using performance dashboard information, available through the electronic systems, to make decisions such as deploying staff or initiating changes in practice. An audit and assurance committee monitored financial statements, corporate, clinical and governance matters and assisted the board in the oversight of risk management. They also had oversight of compliance with corporate governance standards and matters relating to the external audit function.
- Managers we spoke with were clear about the governance and leadership of the service. There were executive and non-executive board members, a chair of the board and a managing director. The board set strategy, supervised the work of the executive in delivery of the strategy and sought assurance that systems of control were accurate and reliable. The board aimed to set and lead a positive culture being accountable to key stakeholders. The Wiltshire Health and Care LLP executive committee had been established as the main forum through which formal operational management decisions would be made. One change that was made when the organisation was formed in July 2016 was to change from having three locality heads to two heads of operations. One head of operations for community and inpatient services, and a head of operations for specialist services. Managers we spoke with felt this had given them a clearer line of governance and improved the consistency of service delivery.
- Heads of operations, including specialist services, development and performance and quality and finance reported to the board.
- The clinical director worked with the three NHS acute trusts who were stakeholders in the partnership. They also linked with the patient voice non-executive representative on the board, and two primary care clinicians who were non-executives. There was also a clinical reference group, whose aims included ensuring that the clinical documentation was patient focused and followed a common assessment framework. It also aimed to ensure that the holistic assessment and care of patients was used consistently.
- The heads of operations were responsible for ensuring that structures, processes and controls were in place and operated effectively. This enabled governance decisions to be made and direction set, to establish work streams and new services. An operations management team provided mutual leadership and peer support. It included four community services' managers (team leaders) and a specialist nurse. They met to discuss and take decisions regarding:
  - Budget management in relation to overall performance for example commissioning for quality and innovation or improvement projects, management mechanisms and local time limited targets. For example, they had looked at savings on dressings with a formulary for consistency.
  - Management and support of staff in terms of overall performance, for example, staff turnover, sickness and training.
  - Performance as reflected in the dashboard against targets, for example, end of life care.
  - Business planning including business continuity, for example, escalation and resilience.
  - Progress against projects and new services.
  - Issues and challenges that face the teams and ward (from a staff or patient perspective).
- The head of quality was responsible for assuring the board of quality (safety, effectiveness, patient and staff experience, and the sustainability of services) in

community services. They oversaw the agreed clinical governance framework and quality strategies to ensure the provider met all relevant statutory, regulatory and legal obligations.

- There was a structured management arrangement within the community teams and staff at all levels understood how this management structure worked. Staff were positive about the local management support available to them and told us that their line managers were accessible to teams and supportive.

### Culture within this service

- We found there was a positive and motivated culture within the community adults' services. The various teams expressed pride at the quality of service delivered and the care and treatment patients were afforded. Staff felt valued and respected. All staff we spoke with felt they were appreciated for the role they performed and the majority told us they were proud of their service. All staff we spoke with were positive about the organisation and felt engaged with the development of the services provided.
- The provider had involved the workforce in developing a set of organisational values, which were in the process of being embedded. We saw that some teams had developed some of their own team values. For example, the Chippenham community team had an away day for all the staff and had produced values and vision for the team around competence and empathy for patients.
- Leaders encouraged appreciative, supportive relationships among staff. Staff we spoke with felt respected and valued. We were told action was taken to address behaviour and performance that was inconsistent with the vision and values of the organisation.
- The culture of the organisation was centred on the needs and experiences of patients who used services. The culture encouraged candour, openness and honesty.
- There was a strong emphasis on promoting staff safety particularly in the varied practical lone-working arrangements.

### Public engagement

- There had not been extensive gathering of people's views and experiences since the establishment of the organisation in July 2016. However, we saw evidence that there was ongoing work to develop the gaining of feedback from the patients and families who used the community adults' services.
- The provider used the national NHS Friends and Family Test questionnaires for patients to hear their views. We saw that the leaflets were distributed to patients and that information was displayed in waiting areas in the clinics we visited.
- The tissue viability service had a system for surveying patients on a regular basis to get feedback. Twice a year, 10 randomly selected patients were sent satisfaction questionnaires with the feedback being provided directly to the team.
- There had also been a number of "cluster events" organised where patients, carers, voluntary groups, GPs and social service staff met to discuss service provision. These were organised along the lines of a "speed dating" format to increase interaction and networking opportunities for people.

### Staff engagement

- The provider had processes to involve staff in the development of services. This included collecting their views and ensuring they could raise concerns, suggest ideas and receive feedback.
- The provider had consulted with staff to produce organisational values supporting change or adapting in a changing community. The values were, 'integrity', 'quality' and 'building and strengthening partnerships'. An away day was held with team leaders and ward managers to gather initial thoughts and ideas as to what the values and behaviours could look like for Wiltshire Health and Care. This was followed with a survey to all staff and a further workshop with a range of staff from different teams, professions and roles, alongside Healthwatch volunteers.
- We spoke with several staff at a range of levels in the organisation who had been part of developing the organisation's values. Staff we spoke with knew what the values were and understood how they influenced their work. Staff were actively engaged and their views were reflected in the planning and delivery of services and shape of the culture of the organisation. For example, the chair, managing director and other senior managers had visited community teams, visited wards and engaged with staff on 'away days' on several occasions in the previous year. The managing director

undertook drop-in visits to Warminster and Wilton community teams after mobile working had commenced on 28 September 2016 to see how it was developing.

- The managing director had organised staff forums where issues could be raised. Following these meetings, written feedback was provided as what action was being taken. Following a concern about the time it was taking to complete some continuing health care assessments for patients, a meeting was arranged with the local clinical commissioning group. Community staff participated in this to share their views.
- Other examples of staff engagement included staff having a vote on support workers' uniforms. There were feedback questionnaires about the mobile working experience. A monthly newsletter was being sent to all staff, and open forums held which any staff could attend to directly question senior managers.
- There was a plan to improve recruitment and retention of staff to ensure that the right staff were recruited to the right roles, and to support increased retention of staff within the provider. The provider was aware of the risks of an ageing workforce in maintaining the numbers of staff required to deliver services.
- Staff survey results were analysed to understand where staff were dissatisfied and to understand where retention could be increased.
- There was a plan for a 'Staff Voice' forum and a survey to review the benefit and requirements of implementing these each quarter. The forum was to understand from staff what the direct challenges were to their roles. In addition, to look to support resolution and increase communication in those areas and support staff feeling valued and engaged.

### Innovation, improvement and sustainability

- Managers and frontline staff were encouraged and supported to be innovative and continuously improve services where possible.
- After recognising there was a gap in the provision for treatment and assessment for vasovagal syncope episodes, the physiotherapy team had set up a course for staff to develop their skills in assessing and treating patients.
- The continence service had developed the use of Biofeedback in managing female continence, and also "trial without catheter" care. They had also provided a level one continence assessment for care homes to use which they could complete and send into the service. They had provided training four times a year for care home staff to promote their understanding of continence management generally, as well as how to complete the assessments.
- Innovative techniques were being used in the management of pressure care wounds.
- Community nurses were starting to use mobile heart monitor technology for patients in their own homes.