

Lancashire Care NHS Foundation Trust

RW5HQ

# Community health services for adults

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW5RG	Barbara Castle Way Health Centre	Podiatry/Treatment room services	BB2 1AX
RW5HQ	Blackburn Innovation Centre	Integrated Nursing Teams/Case managers/Single Point of Access/IVA Therapy/Rapid Response/Stroke Team/Pulmonary rehabilitation/Oxygen team	BB1 2FD
RW5HQ	Buckshaw Village Surgery Chorley	Integrated Nursing Team	PR7 7HZ
RW5AQ	Chorley Health Centre	Treatment Room Service/Podiatry	PR7 2TH
RW5HQ	Clayton Brook Clinic	Care Home effective support Service	PR5 8ES
RW5HQ	Cop Lane Health Centre	Integrated Nursing Team	PR1 0SR
RW5HQ	Coppull Clinic	Integrated Nursing Team	PR7 5EJ
RW5X9	Darwen Health Centre	Tissue Viability Service	BB3 1PY
RW5HQ	Leyland Clinic	Podiatry	PR25 2TN
RW5HQ	Leyland House Leyland	Integrated Nursing Teams	PR26 6TR
RW5AQ	Longridge Community Hospital	Heart Failure Clinic/Leg Ulcer Clinic/Integrated Nursing Team/Phlebotomy	PR3 3WQ
RW5RP	Minerva Health Centre Preston	Communicable Disease Service/Diabetes Service/Cardio/Respiratory Services	PR1 6SB
RW5HQ	Ribbleton Clinic Preston	Community Neurology Team	PR2 6HT
RW5EE	Royal Preston Hospital	Discharge Planning Team	PR2 9HT
RW5HQ	St Georges Surgery Blackburn	Integrated Nursing Team	BB2 3HS

# Summary of findings



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

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

Where applicable, we have reported on each core service provided by Lancashire Care NHS Foundation Trust and these are brought together to inform our overall judgement of Requires Improvement

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

Overall, we have rated community health services for adults as “Requires Improvement”. This is because:

- We were not assured that all lessons learnt were being identified in the root cause analysis investigations we reviewed or areas identified for improvement were being monitored.
- In the Integrated Nursing Teams (INTs) in Chorley and South Ribble, and Blackburn with Darwen localities, we found 18 out of 20 patients records where patients had died, that did not have an end of life care plan in place.
- In Chorley and South Ribble INTs and the treatment room service, there were not always care plans in place for problems that had been identified. We found incomplete assessments, wound evaluation charts not updated at least fortnightly in line with the trust management of wound’s policy, and not all entries had the time of entry documented.
- Data for mandatory training and appraisal rates provided by the trust was not as accurate and up to date as data held at team level.
- An audit had been performed to monitor storage of medicines and had reported issues with clinic room temperatures not being monitored which we observed at the time of our inspection and we were not assured that clear actions and improvements had been made. When staff had raised issues with the temperature recordings being high in clinics and treatment rooms, as per the trust policy, no action had been taken.
- The Integrated Nursing Teams (INTs) were not using a staffing acuity tool and of the seven INTs we visited we found two that mentioned the use of a caseload weighting tool. Since our previous inspection the trust had been reviewing potential tools and had analysed activity data to inform a new model of care. Due to on going transformation work at the trust, the business case for staffing against activity had been placed on hold.
- We requested documentation audits specifically for the INTs and were informed by the trust that the INTs had not participated in a documentation audit for

the 12 months prior to our inspection.

Documentation issues had been highlighted in root cause analysis investigations in relation to pressure area care.

- The trust data identified that a total of 575 pressure ulcers had developed whilst patients were on the services caseloads. There were 13 of these that deteriorated which suggest that once a pressure ulcer developed care and prevention strategies were implemented to prevent any deterioration. We were not assured that prevention strategies were put in place to prevent the development of pressure damage. During our inspection we found care plans and risk assessments were not always in place or updated and this was also identified as part of a root cause analysis investigation.
- Systems in place to ensure staff were safe at the end of an evening shift were not always followed.

However:

- The trust had a range of mandatory training available to staff and staff compliance met the trust target of 85%.
- Staff had an annual appraisal where learning needs were identified. The trust provided opportunities for staff to develop which included placements at education establishments. Developmental roles for band five nurses had been implemented for staff wanting to develop into leadership roles. This also assisted the trust to develop and recruit senior nurses from within their own workforce.
- There was good evidence of services and disciplines working together to improve services for patients and included: the intensive home support service, the discharge planning team, the Care Home Effective Support Service (CHESS) Team and the diabetes service.
- People who used the services were able to ask questions, discuss care, and were involved with decision making. The services received positive comments about the staff and the care provided and patients were treated with dignity and respect.

# Summary of findings

- There was evidence of delivering services to meet patient's needs. There had been a review of the community matron service which identified the need for specialist Chronic Obstructive Pulmonary Disease (COPD) services and rapid access to care to prevent hospital admissions. There was evidence of multi-agency and patient focus groups to inform delivery of services which resulted in a more integrated approach to service delivery via the intensive home support service.
- Podiatry services had implemented a one stop assessment for patients who may require nail surgery which resulted in a reduction of additional appointments for patients and an increase in podiatry staff availability. The service had direct access to a vascular surgeon where they could arrange urgent appointments and the service could order diagnostic tests prior to the patient attending the appointment to enable the consultant to have sight of all information at the time of consultation.
- Staff felt supported and listened to and there was professional forums for nurses and allied health professionals.

# Summary of findings

## Background to the service

Lancashire Care NHS Foundation Trust provides community-based health services for adults in Lancashire in three localities: Chorley and South Ribble, Preston, and Blackburn with Darwen. These include the provision of community nursing, community therapy, and specialist services to people in their own homes such as, wound care, care for patients approaching end of life, rapid assessment to prevent hospital admissions, physiotherapy and occupational therapy.

Lancashire Care NHS Foundation Trust also provide clinic based services across the three localities and included treatment room services for patients who are not housebound, specialist nursing and therapy treatment and assessment clinics.

As part of our inspection we visited services across the three localities which included: tissue viability and lymphoedema, discharge planning, podiatry,

communicable diseases, diabetes, phlebotomy, treatment room services, community stroke and neurological rehabilitation, care home effective support team, single point of access, rapid response, complex case managers, pulmonary rehabilitation, heart failure, chronic fatigue, intra-venous team, dermatology and integrated nursing teams. We accompanied community nurses on home visits and observed practice in treatment rooms and clinics.

As part of this inspection we reviewed data that the trust provided, we reviewed 62 sets of patient records across the integrated community nursing services, treatment room service, and specialist services. We spoke with 81 members of staff of various grades and disciplines, 11 senior managers, 12 patients, three carers, and accompanied staff on five home visits.

## Our inspection team

Our inspection team was led by:

Chair: Neil Carr OBE, Chief Executive South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Inspection Managers: Sharon Marston and Nicola Kemp, Care Quality Commission

The team included three CQC inspectors and a variety of specialists including: two community nurses, an occupational therapist, a physiotherapist, and a specialist nurse for end of life.

## Why we carried out this inspection

We carried out a comprehensive inspection in April 2015 and rated the service as “Requires Improvement” overall.

We judged the service to be “Requires Improvement” for safe and effective and “Good” for caring, responsive and well-led. We issued requirement notices for breaches in relation to:

Regulation 9: Person centred care

Regulation 12: Safe care and treatment

Regulation 17: Good governance

During this inspection, the service had met the requirement notices we issued during our last inspection.

## 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?



# Summary of findings

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

Before visiting the services, we reviewed a range of information we hold about this service and asked other organisations to share what they knew.

We carried out an announced inspection between 12 to 15 September 2016.

Prior to the visit we held focus groups with a range of staff who worked within the service, such as nurses and allied health professionals.

During the visit we spoke with 81 members of staff of various grades and disciplines, 11 senior managers, 12 patients, three carers, and accompanied staff on five home visits. We reviewed 62 sets of patient records in total. We observed how people were being cared for in their own homes, and in clinics. Patients and families also shared information about their experiences of community services via comment cards that we left in various community locations across Lancashire.

## What people who use the provider say

People who used this service told us at the time of our inspection:

- 'I feel comfortable knowing that I can ring for help and advice and can be seen on the same day if needed', 'you feel as if you matter', and we feel listened to'.
- The diabetes service audited 30 patients who had received the service from 1 April 2016 to 30 June 2016 and 92 % of the sample stated they felt more confident to manage their diabetes.

- An audit performed by the tissue viability and lymphoedema service performed an on patients receiving the lymphoedema service from March 2016 to August 2016 and found that of the six patients that stated they were experiencing pain prior to treatment, all six identified a reduction in pain following treatment from the service.

## Good practice

- The Podiatry service had daily access to a vascular consultant who could see the patient the same day. The service was able to generate a letter for the patient to take with them to the appointment and were able to request basic blood tests and x-rays prior to the appointment. This reduced the need for additional appointment for the patient and provided the vascular consultant with all the information required to inform future care planning.
- The Care Home Support Service (CHESS) team were working closely with care home staff and had reduced unnecessary admissions to hospital and had implemented a 'hydration kit' for which they had been nominated for an award by the Royal College of Nursing.

## Areas for improvement

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

**Action the provider MUST take to improve**

The service must:

- Ensure that robust systems are in place and monitored, and patients on the caseload are appropriately risk assessed to reduce the level of incidence of harm due to developing a pressure ulcer

# Summary of findings

## Action the provider SHOULD take to improve

The service should:

- Review root cause analysis investigations to capture all learning as actions on the action plan.
- Have an end of life care plan embedded within the services which should be used for all patients identified as approaching end of life.
- Consider an audit of peoples experience when they have experienced a close death as per National Institute for Clinical Effectiveness (NICE) guidelines
- Identify adherence to National Institute for Clinical Effectiveness (NICE) guidelines for patients approaching end of life as a risk on the community health services for adults risk register.
- Review and utilise safer staffing tools and caseload weighting tools to determine the number of staff required to safely and effectively manage nursing caseloads.
- Consider a system that enables all health needs and patient risks identified at the time of assessment to have a care plan in place.
- Review processes in place to enable mandatory training data held at trust level accurately reflects compliance at team level.
- Where teams identify a concern in relation to room temperatures actions are taken to resolve the issues in a timely manner.
- Monitor to determine if risk assessments are completed to ensure all patient risks are identified and minimised to reduce harm, in particular for those patients who are receiving end of life care.
- Action in relation to the duty of candour is clearly identified in the root cause analysis investigation.
- Containers of creams used in treatment rooms and clinics are clearly labelled with the date they were opened.
- Ensure all treatment room areas to have completed cleaning schedules
- Consider the use of a universal pain assessment tool to assess and evaluate the level of a patient's pain and the effectiveness of treatment.
- Document in the patient record that consent has been gained from the patient.
- Improve compliance with Mental Capacity Act training.
- Improve systems for staff that are lone working in particular in the evenings.
- Ensure that where there are several community health services for adults involved in a patient's care, the key worker is clearly identified in the patient record.
- Have processes in place for all services that have an identified timeframe to respond that enables response times to be regularly monitored and reviewed.
- Document the time of all entries on the patient records
- Monitor why appointments are cancelled by services to enable identification of service pressures and service development.

Lancashire Care NHS Foundation Trust

# Community health services for adults

**Detailed findings from this inspection**

Requires improvement 

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We rated community health services for adults as 'requires improvement' for safe because:

- The Integrated Nursing Teams (INTs) were not using a staffing acuity tool to determine safe staffing. Of the seven INTs we visited, we found two that mentioned the use of a caseload weighting tool. Since our previous inspection the trust had been reviewing potential tools and had analysed activity data to inform a new model of care. However this work was not being progressed at the time of our inspection.
- We were not assured that all lessons learnt were being identified in the root cause analysis investigations we reviewed.
- Data for mandatory training provided by the trust was not as accurate and up to date as data held at team level.
- An audit had been performed to monitor the storage of medicines and had reported issues with clinic room temperatures not being monitored which we observed at the time of our inspection. We were not assured that clear actions and improvements had been made. When staff had raised issues with the temperature recordings being high in clinics and treatment rooms, as per the trust policy, no action had been taken.
- Risk assessments were available, however, we found that these were not always completed and patient risks may not be appropriately managed.
- The trust had guidelines for the prevention and management of pressure ulceration which identified that all patients on admission to the caseloads should have a completed pressure ulcer risk assessment. We found of the 11 records we reviewed five did not have a completed pressure ulcer risk assessment at the time of our inspection.
- Systems in place to ensure staff were safe at the end of an evening shift were not always followed.
- We found a tub containing cream that was used for multiple patients in a treatment room that was not labelled with the date it was opened.

However:

## Are services safe?

- All equipment we observed had been maintenance checked within the 12 months prior to our inspection.
- Patients were protected against healthcare associated infection and staff adhered to infection control policies.
- The total rate of staff vacancies overall for the adult community services was 9.2% which was better than the trust average of 12.5%. Staff were able to use bank and overtime to backfill vacancies and sickness.

### Safety performance

- The community health services for adults used the NHS safety thermometer to monitor their safety performance. The NHS safety thermometer is a national improvement tool for measuring, monitoring, and analysing avoidable harm to patients and ‘harm free’ care. Performance against the four possible harms include: falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE).
- The safety thermometer was completed on one day each month for patients receiving a home visit from the Integrated Nursing Teams (INT). We reviewed the findings from May 2016 data and found a total of 1164 patients trust wide had been included and there was 1.5% harm due to grade four pressure damage and 2.8% harm due to grade two pressure damage. We reviewed the results for the same period for the Blackburn with Darwen East INT and found from the total of 48 patients included there had been no harms due to falls, CAUTI, VTEs, there had been a 2% harm recorded for grade two pressure damage.
- Pressure ulcer incidence was recorded via the trust’s electronic incident reporting system.
- Monthly meetings were held in relation to harm free care and findings were disseminated through professional forums to cascade to staff to improve services.
- A pressure ulcer audit report was performed in April 2016 which identified ‘impaired mobility’ as a risk factor. The INTs visited patients who were housebound which would indicate the patients had impaired mobility and would all be eligible for a completed risk assessment at the time of admission to the caseload. The pressure ulcer audit report identified that, overall the adult community services were 85% compliant with the standards, which was better than the trust target of 80%: however, not all patients with a risk factor received a risk assessment at the first visit and patients and their carers were not always given information on relieving pressure or information to prevent pressure damage. The audit also highlighted that there was evidence that once the Waterlow Risk Assessment had been completed, this was not being re-assessed, and where care plans were put in place these were not being reviewed. There was an action plan which included reminding staff to complete documentation and to re-audit as part of the 2016/2017 audit programme.
- We noted in the report that patients who were on the community matron caseload were excluded from the audit report as pressure ulcer risk assessment historically fell under the remit of the district nursing teams: however, not all patients on the community matron caseload would be under the care of the district nursing service. Early identification of risks could be delayed until the patient developed pressure damage. We found, of the 973 pressure ulcers reported during the period 1 September 2015 and 31 August 2016, 575 pressure ulcers developed in the trust’s care which equated to 59.1%.

### Incident reporting, learning and improvement

- The trust had an electronic system in place to report incidents and all staff we spoke with knew how to use the system. Community health services for adults reported a total of 7786 incidents in the 12 month period from 1 September 2015 to the 31 August 2016. Of the 7786 incidents, 892 (11.5%) were classed as ‘Catastrophic’ or ‘severe’. There were 973 incidents that were due to pressure ulcers of which 575 developed whilst on the service caseload which equates to 59.1% of all pressure ulcers.
- There were 13 serious incidents in relation to grade three or grade four pressure ulcers that required investigation reported within community health services for adults between 2 April 2015 and 27 March 2016. The 13 incidents occurred whilst patients were receiving care from the community nursing services.
- We reviewed two of the 13 root cause analysis (RCA) investigations for these serious incidents. Both RCAs had a chronology of events, identified contributory factors, lessons learnt, and an action plan identified:

## Are services safe?

however, there were additional areas for improvement within the RCA findings which were not highlighted for action. A wound had been downgraded yet training on grading pressure ulcers was not an identified action and according to the chronology provided a dressing was not changed for at least 13 days however, this was not identified as a contributing factor or an action. We were not assured that staff were identifying all potential lessons when performing an RCA investigation, and we did not see RCA investigation training identified on the training matrix we observed at several clinics during our inspection.

- Since these two investigations were performed, the trust had introduced a trust-wide ‘investigations and learning team’ which was responsible for completing all serious incident investigations graded four or five. All the investigators within this team were required to complete a postgraduate certificate in serious incident investigations to support them within this role. Incidents graded level three and below remained within the networks for senior and local managers review. The trust required all managers undertaking level one to three reviews to be trained in root cause analysis and Human Factors training.
- Lessons learnt from incidents were disseminated to staff via staff forums, team meetings, news letters and emails. We observed evidence where improvements were made in practice from lessons learnt from incidents. An incident review group was formed to review any reported incidents relating to insulin. This had resulted in new processes for filing old prescription charts and for visiting patients in residential care.
- Following an incident where a cotton bud was left in a patient’s toe after receiving nail surgery by the podiatry service, a checklist had been developed, and was now used for patients having nail surgery to reduce future risks of similar incidents.
- There was limited documented evidence of how duty of candour had been implemented in the RCAs we reviewed. We asked staff nurses and therapy staff what they understood by the duty of candour and all described it as being open and honest with patients when harm had occurred. The duty of candour did not form part of the mandatory training at the time of our previous inspection. We asked two staff about training and they told us there was training on-line they could

access for duty of candour however, there were no uptake figures provided by the trust in the essential or mandatory training figures for community health services for adults.

### Duty of Candour

- There was limited documented evidence of how duty of candour had been implemented in the RCAs we reviewed. We asked staff nurses and therapy staff what they understood by the duty of candour and all described it as being open and honest with patients when harm had occurred. The duty of candour did not form part of the mandatory training at the time of our previous inspection. We asked two staff about training and they told us there was training on-line they could access for duty of candour however, there were no uptake figures provided by the trust in the essential or mandatory training figures for community health services for adults.

### Safeguarding

- Staff understood and were able to explain the process for reporting safeguarding concerns. Patients with grade three and above pressure ulcers were referred to the trusts and local council’s safeguarding teams.
- The trust offered mandatory training for safeguarding adults and children and staff reported they had completed the training. Data received from the trust identified community health services for adults as 96% compliant with safeguarding children level one, and 85% compliant with level two. Data received from the trust identified community health services for adults as 91% compliant with safeguarding adult’s level one and 45% compliant with adult safeguarding level two. However, each team we visited at the time of our inspection held a team training matrix and the ones we observed identified staff were meeting the trust target of 85% compliance with all mandatory training with the exception of a small number of staff that had been on long term sick leave.
- Staff reported good timely responses from the safeguarding team and would ring the team if they needed advice.

### Medicines

- Community nurses administered controlled drugs via sub-cutaneous injection and via the T34 syringe driver

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pumps in line with the trust policy and National Institute for Health and Care Excellence (NICE). Controlled drugs were collected from the pharmacy by carers or the patient's family or were delivered to the patients' home by a pharmacy.

- Controlled drugs were kept in the patient's own home and stock checks and administration records were recorded in the patient held record.
- When drugs were no longer required, family and carers were asked to return them to the pharmacy. However, if the nurse had identified any issues of concern, the nurses would destroy the drugs and use a controlled drug destruction jar which allowed rapid and successful denaturing of pharmaceutical products.
- Staff reported having a trust wide wound care formulary to work from for providing wound care to promote a standardised approach. The INTs had a first dressing initiative in place where they could order stock from stores to be delivered and stored at the bases to enable them to have an initial dressing for any new wounds. The INTs had band six and band seven staff that held a non-medical prescribing qualification and could prescribe dressings. When these staff were not available the nurses used a prescription request form which was faxed to the patient's own GP to prescribe. Nurse's prescription pads were stored in locked cabinets when not in use.
- In one treatment room in Chorley Health Centre we observed dressings stored on wire trays attached to the walls. We observed a tub of liquid paraffin being used for multiple patients. Staff told us they used a disposable spatula to get the cream from the jar to avoid cross contamination, however; there was no date on the tub to indicate how long the product had been open and in use for. A 'good practice guide' of three months from the date of opening for creams that has a lid on is often used; however, this was unable to be monitored.
- There was no temperature recording record within this treatment room to determine if dressings were being stored appropriately. An audit of 'Storage of Medicines' was completed for the period January 2016 to March

2016 and this had highlighted that clinic room temperatures were not always being monitored. The audit identified recommendations but no action plan for improvement.

### Environment and equipment

- Equipment for patients' homes was ordered on-line from an equipment store and equipment was accessible seven days a week. The provider of the equipment had recently changed and staff told us there had been some initial delays in getting equipment. We saw incidents had been reported and staff told us the service was improving.
- The INTs used glucometer machines to monitor patient's blood sugar levels. We were informed by an administrator that there was a monthly safety control in place with the laboratory. No reports for the results were available to the team and we were advised a report was only received if the machines were out of the test range. We reviewed the daily check control records for two machines at St Georges Clinic which identified control checks were being recorded on the days required prior to using the machine.
- Staff attended the trust moving and handling mandatory training, and moving and handling equipment could be ordered for individual patients and included: slide sheets, hoists and slings, and electric hospital type beds.
- There were syringe driver pumps available for community nurses to use to administer sub-cutaneous medication to patients who were approaching end of life. We checked syringe drivers at Buckshaw Village Clinic and St Georges Clinic and found them all to have been maintenance checked within the 12 months prior to our inspection. There were no syringe drivers available to review at the INTs based at Leyland House. However, staff informed us they could access one from another team, if required.
- We visited treatment and clinic rooms across the three localities and found the rooms to be visibly clean and accessible. We saw the yellow bag system in place to dispose of clinical waste and handwashing facilities and hand gel was available. We observed signage above the sink at Leyland clinic with information relating to how to perform the correct hand washing technique; however,

## Are services safe?

the NHS organisation identified on the signage was not Lancashire Care NHS Trust. Sharps bins were situated on the clinical trolleys or worktops and were labelled and closed when not in use.

- We checked the defibrillator machine at Leyland clinic and found it to be checked on a daily basis.
- There was daily monitoring of temperatures taking place. Staff told us they were advised to contact medicines management team if temperatures were recorded over 25 degrees Celsius. At Leyland clinic, of the last eight recordings, six identified the temperature was above the recommended range. Staff had reported this as per trust policy but there had been no action taken.
- We found one treatment room in Chorley Health Centre had no thermometer and there was no record of temperature being monitored. Although there was no medicine cupboard in the treatment room, there was dressings being stored which were included as a medicine in the trust's policy for the 'procedure for room temperature monitoring' March 2015.
- There was a contract with a local provider to supply a service to sterilise instruments used to perform podiatry treatment.
- At the time of our previous inspection we found specimens and medicines stored in the same fridge at Leyland clinic; however, we found at the time of our inspection, there was no longer a fridge at this site.
- We found all equipment that we reviewed to have had maintenance checks within the 12 months prior to our inspection and included: curtains, fans, treatment couches, syringe drivers, and ear syringing equipment.

### Quality of records

- Paper held patient records were used across the community services at the time of our inspection. Community nursing records were held by the patient in their home setting. Treatment room notes were stored in the clinic room in locked cabinets. Therapy staff transported patient records when visiting patients in the community. Therefore, all services had access to up to date information with regards to the patient's progress.
- A tracking system was used to record the movement of records across locations.

- There was an electronic care record which held patient demographic data and was used to record activity and contact details. The system also held the data in relation to further planned visits. Staff in the INTs had hand held devices to access the information, view their visit list, and record their activity whilst out of the office. There were on going issues with connectivity with the electronic care record however; work was on going with the information technology department to resolve issues as quickly as possible. There was on going work in progress within the trust to implement a new clinical electronic patient record.
- At the time of our previous inspection, the continence service had not performed a documentation audit for over 12 months. We found that one had been completed after our last inspection and on the whole was compliant with the trust's standards with three actions identified and completed.
- We found four out of nine records in the treatment room service did not have the time documented for all entries. This had been identified in a trust documentation audit in treatment rooms in September 2015 where five out of ten records did not have the time of all the entries documented.
- We requested all documentation audits completed 12 months prior to August 2016 for community health services for adults and were provided with ten audits in total. The audits provided were for services which included: communicable disease, dietetics, rheumatology, treatment room services, podiatry, diabetic service, tissue viability and lymphoedema services and cardio-respiratory services, and an audit of prescription charts. We were provided an audit for the community neurological team however we did not include that audit as it was from April 2015.
- We were not provided any documentation audits for the INTs and the trust informed us that none had been completed. All the audits had identified recommendations where standards were not being met however; we saw action plans with actions either completed or on going. We reviewed an audit for podiatry and treatment room services where 42 of the 47 standards scored 100% and included all entries timed and achieved an overall compliance of 89%. We reviewed a prescription chart audit for adult community services from August 2015 and found 96 charts had been

## Are services safe?

assessed and of the 28 standards 18 achieved over 90% compliance and the four lowest compliance scores related to nicotine replacement assessments and patient details on the back of charts not being completed. The audit was completed annually and had identified improvements in documentation from the previous year.

- We reviewed the trust's policy and guidelines for The Prevention and Management of Pressure Ulceration (May 2013) and found areas of the policy and guidelines unclear. In the guidelines there was a list of situations and diagnosis which indicated a risk of pressure damage. The policy stated 'once identified as 'at risk' it is the responsibility of the healthcare professional completing the risk assessment to document the risk'. In the guidelines the standard suggests that all patients being admitted to the caseload should have a completed Waterlow Risk Assessment. We found three out of 35 records we reviewed did not have a completed Waterlow Risk Assessment but met the criteria in the guidelines as being at risk. The three records related to patients attending treatment room services.
- We found in six of the 20 records there was no 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms.
- There had been an end of life re-audit in April 2016. The aim of the audit was to determine adherence to the National Institute for Care Excellence Quality Standard 13 for End of Life for the statements failing to reach compliance at the initial audit in October 2013. The re-audit had demonstrated that, following the remedial work that had taken place within the network for the lower scoring statement, the baseline audit had achieved an overall compliance of 46%. Although the standard had not met full compliance there was no action plan identified and it was stated at the end of the audit that there were no plans to re-audit as the new individualised care plan for end of life would be audited after a 12 month period. We reviewed the risk register for community health services for adults and we did not see the risk of non-compliance with NICE Guidelines in relation to end of life care identified as a risk.

### Cleanliness, infection control and hygiene

- Compliance with mandatory training for infection control for clinical staff was 90.9% which was above the trust target of 85%.
- We reviewed hand washing audits that had been completed for the period April 2016 to June 2016 for clinic based services and INTs. We reviewed audits for 35 teams and found two teams had not returned the audit and 30 had passed the audit as compliant. The three teams audited as not compliant related to storage of personal protective equipment, availability of soap and towels at sinks, and staff not adhering to 'bare below the elbow' guidelines: however, at the time of our inspection we observed staff complying with the trust's policies and guidance on the use of personal protective equipment and adhered to "bare below the elbow" guidelines. There was ample access to hand washing facilities and personal protective equipment such as aprons and gloves in the treatment rooms we visited.
- In the health centres we visited, there was a good amount of seating in waiting areas and they appeared visibly clean and tidy.
- We observed cleaning rotas for the treatment rooms in Chorley Health Centre completed for the 12, 13 and 14 September 2016. When we asked to see previous rotas the staff were unable to locate them so we had little evidence to assure us this occurred on a daily basis at this clinic.
- Daily cleaning rotas that we observed at Leyland clinic and Barbara Castle Way clinic were in place and completed daily.
- Patient Led Assessments of the Care Environment (PLACE) are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. However, the trust only provided data for inpatient services.
- We did not see any 'I am clean stickers' on equipment at the clinics we visited; however, we did see staff clean equipment with decontaminating wipes after they had used equipment.



# Are services safe?

## Mandatory training

- A mandatory training programme was in place for staff across the trust. This was mostly delivered via the trust's e-learning system which was internet based and therefore accessible for staff 24 hours a day. Mandatory training included: equality and diversity, infection control, information governance, and moving and handling.
- Data provided by the trust identified the community health services for adults were overall 86.8% compliant with mandatory training which was better than the trust target of 85%. However, there were areas when looked at separately where the 85% was not achieved which included basic life support and moving and handling level three. However, when we asked staff in the teams we visited about their training, they were able to show us a team service matrix of training compliance which suggested most of them were up to date. They told us training was monitored and they were notified when further training was due. This demonstrated that the central monitoring system did not provide a true reflection of the attendance at training and this was the case at our previous inspection.

## Assessing and responding to patient risk

- INTs prioritised visits based on a patient's condition and immediate needs and had an available printed list of patients they deemed as vulnerable.
- Staff from the podiatry service confirmed that people with wounds or infections would be graded as high risk to ensure they were prioritised. The podiatrist could request a range of diagnostic tests and had access to the vascular consultant's diary to book urgent appointments for patients.
- The Care Home Effective Support Service (CHESS) supported patients in the care home setting to avoid unnecessary admissions to hospital.
- Fire and risk assessments were available in the patient's records for patients receiving community nursing in their own home. However, in 20 records that we reviewed for patients approaching end of life, none of the assessments had been completed.
- We reviewed four patient records for patients receiving care in their own home from community nurses and found all four had a pressure ulcer risk assessment

completed and of the two that were identified as being at risk; a pressure ulcer management plan was in place. We reviewed four patient records for patients attending treatment room services and found that two had a completed pressure ulcer risk assessment and both had a pressure ulcer management plan in place. We reviewed three records for patients receiving care from specialist services which included: the intravenous access team and the respiratory service and found two records did not have a pressure ulcer risk assessment completed, one had the assessment completed, no score was documented however, and a pressure ulcer management plan was in place.

- Handovers within the INTs varied across the trust with some handovers taking place in the mornings, some at lunch time, and others in the afternoon. We observed one hand over taking place in an INT in the Chorley and South Ribble Locality, and saw that issues were discussed and actions for the next visits were captured on the electronic system. However, as there were no handover sheets used, there was a lack of evidence to determine how actions were recorded and no identification of lines of responsibility for actions.
- The overnight community nursing service came on duty prior to the day service going off duty which enabled a handover via the telephone between the two services. In Chorley and South Ribble there were plans for the overnight staff to attend the Buckshaw Village clinic to have face to face handovers from October 2016.

## Staffing levels and caseload

- At the time of our previous inspection we found that community nursing services were not utilising any safer staffing tools to determine the number of staff required to ensure effective and efficient management of the caseloads.
- Staff, the Business Manager, and the Clinical Director told us that a business case had been written based on detailed analysis of activity across nursing and therapy services and a review of available tools to assist caseload management. A decision had been made by the trust not to progress with the business case due to the transformation work that was on going in the trust.
- We asked band seven and band six community nurses how they knew what staff they required and were told this was based on historic practice and clinical

## Are services safe?

judgement. Due to the complexity of the caseloads changing on a daily basis staff told us if they were busy they would prioritise patients with the highest need to ensure they received a visit. We saw that a Purple Red Amber Green (PRAG) tool had been developed on the electronic system to enable the INTs to identify patient's dependency based on their needs. For example, patients identified as essential visits or required a visit that was likely to take more than 60 minutes were identified as purple. Patients with a lower need or requiring a shorter time to visit would be identified as amber or green.

- Bank staff could be used and there was a reliance on the goodwill of the trust's own staff to work additional hours. There were 309 shifts filled by bank staff and 31 shifts that were not filled. Where shifts were not filled visits were prioritised to those patients with the greater need and identified as purple and red on the PRAG tool, with other visits being rescheduled.
- Data the trust provided for the INTs, phlebotomy and the diabetes service, identified an establishment of 176 whole time equivalent (WTE) qualified nurses with 5.9 WTEs vacancies resulting in a 3% vacancy rate. The establishment for nursing assistants was 56.7 WTEs with 4.5 WTE vacancies resulting in an 8% vacancy rate. There was an on going recruitment plan in place to recruit to vacancies.
- The total number of substantive staff in post across all community health services for adults at 30 April 2016 was 839. There were 65 staff that had left the trust in the

previous 12 months (7.7%) which was better than the trust average of 14.3%. The total rate of staff vacancies overall for the services was 9.2% which was better than the trust average of 12.5%. The staff sickness rate across the service was 5.7% which was worse than the trust average of 4.8%. We saw that recruitment of senior nurses was identified on the service risk register and recruitment processes were in progress at the time of our inspection.

### Managing anticipated risks

- The INT teams all had a printed list of their priority patients which was updated on a daily basis which ensured the most vulnerable patients were visited and were identifiable should the electronic system fail.
- The community services had plans in place should a major incident occur and a policy was in place. Staff gave us examples of how they would manage during times of bad weather which included how they would prioritise home visits and services, and how staff would attend their nearest community base.
- Staff worked on their own during the evening, systems were in place to record that staff were safe at the beginning and end of the shift however, we saw on numerous occasions there was not always a record that staff were safe at the end of the shift and the systems in place were not always completed. The service did have contact details for all staff which included their car registration and make and model should they need to escalate their concern.

# 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 community health services for adults as 'requires improvement' for effective because:

- There was poor compliance with the use of end of life care plans for patients who had died in the previous three months of our inspection. Of the 20 records we reviewed for patients who had died, 18 did not have an end of life care plan in place. There were different versions available at different bases and some staff thought the end of life care plan had been put on hold. The trust identified that of the 349 patients that had died between 1 April 2016 and 30 June 2016 who were on the integrated nursing team caseload, 49.6% did not have an end of life care plan in place. There were no audits performed to determine if people that had experienced a close death felt supported during and after the death. This resulted in a missed opportunity to learn and improve services for patients and those close to them. We did not see a pain assessment scoring tool in any of the INT records we reviewed. In Chorley and South Ribble Integrated Nursing Teams (INTs) and the treatment room service, there were not always care plans in place for problems that had been identified. We found incomplete assessments, wound evaluation charts not updated at least fortnightly in line with the trust management of wound's policy, and not all entries had the time of entry documented.
- We were not assured that the trust policy and guidelines for The Prevention and Management of Pressure Ulceration was always being adhered to. We found, of the 973 pressure ulcers reported during the period 1 September 2015 and 31 August 2016, 59.1% of pressure ulcers developed whilst the patient was in the trust's care. We were concerned about the high incidence of pressure ulcers. We found that 66.4% of staff identified by the trust as requiring training in relation to pressure ulcer management had not accessed any modules on the trust training tracker in the 12 months prior to September 2016.
- We observed staff gaining implied consent from patients; however, we saw little evidence that consent was documented in the patient record.
- The trust had a policy to support staff to receive clinical supervision. We found that 14 teams were not achieving the target of attending four sessions a year.
- Where several services were involved in a patient's care, it was not clear in the patient record who was the key worker or the person responsible for coordinating the patient's care.
- Compliance with training on the Mental Capacity Act level two was less than 75%. Patient capacity was not always documented or completed as part of the assessment in the patient records.

However,

- We found that all six patients who had described experiencing pain due to lymphoedema which is a swelling due to a build-up of fluid experienced a reduction in pain following treatment from the tissue viability and lymphoedema service. The service had also reduced symptoms of heaviness and aching limbs for patients who had received treatment. Patients who had attended the stroke rehabilitation services were achieving improvements in their functional ability.
- Developmental roles for band five nurses had been implemented for staff wanting to develop into leadership roles within the INTs. This also assisted the trust to develop and recruit senior nurses from within their own workforce.
- There was good evidence of services and disciplines working together to improve services for patients and included: the intensive home support service, the discharge planning team, the Care Home Effective Support Service (CHESS) and the diabetes service.

## Evidence based care and treatment

- The trust had a range of policies and clinical guidelines available to staff. These were held on the trust intranet and were readily accessible to staff in the community.

## Are services effective?

- The trust had performed a National Chronic Obstructive Pulmonary Disease (COPD) audit in April 2016 to audit the pulmonary rehabilitation programme against the British Thoracic Society Quality Standards. The audit consisted of 38 patients across the localities. Of the ten standards there were nine standards being met and the one standard not being met was to provide patients with a written on going exercise plan. However, 100% of patients across the localities had a completed health status questionnaire compared to 93% nationally. The clinical audit found that of all patients who commenced a pulmonary rehabilitation programme, in Preston 63% were assessed, enrolled and completed. This was better than the national figure of 60%. Blackburn results were found to be 23%. However, this issue was being addressed by the employment of a trainee practitioner.
- We reviewed one patient record in the pulmonary rehabilitation service and found no care plans documented.
- We reviewed 20 records for patients who had died in the three months prior to our inspection and found 18 records did not have an end of life care plan in place. However, care was clearly documented in the patient record and included symptom control, some discussions with families, and risk assessments. Managers told us they had replaced the Liverpool Care Pathway with an end of life care plan which was continually developed and modified and the final version was agreed and launched on 1 August 2016. There was no evidence of any audit of the interim document to ensure it was fit for purpose. We found that the new documentation was not in all bases, and some staff thought the process was on hold. We were told by managers that some staff had attended training and they were responsible for rolling out the training to others.
- Data provided by the trust for the period 1 April 2016 to 30 June 2016 identified 349 patients that were on the INTs caseload who died and 173 (49.6%) did not have an end of life care-plan in place.
- The trust's Management of Wounds policy stated that all wound evaluation/assessment charts should be updated at least fortnightly. We reviewed four wound evaluation charts for patients who had been attending the treatment room service for wound care and found they were not being completed as per trust policy. One

wound evaluation was recorded on the 30 December 2015 and not repeated until the 9 June 2016. We requested documentation audits for the integrated nursing teams however; the trust informed us that none had been completed in the 12 months prior to our inspection.

- One INT told us about work they were doing in residential homes in an attempt to improve knowledge in relation to preventing and recognising pressure damage.
- We found there was no bereavement data captured and there were no plans to audit the death experience from relatives. Quality standard 14 of the NICE end of life care for adults suggests that people affected by death should feel that information and support was available to them around the time of the death and afterwards, which was appropriate to them and offered at the right time. As this was not audited the opportunity to learn and develop from feedback was limited. Staff told us they knew they did a good job because they received thank you cards which we observed at the time of our inspection.

### Pain relief

- Community nursing services provided care to patients who were palliative and approaching end of life. When a patient was identified as approaching end of life the GP would prescribe anticipatory end of life drugs to prevent any delay should the patient's condition deteriorate. Staff had access to equipment should they need to administer pain relief medication, and patients approaching end of life were prioritised.
- Staff working out of hours had access to GPs, if required, and did not raise any concerns in relation to availability of medication for pain control.
- Pain was managed in a timely manner; however, although we observed pain documented and evaluation sheets in the nursing assessment, we did not see the use of a universal pain scoring tool in the records we reviewed at the time of our inspection.
- If patients were assessed as deteriorating and approaching end of life the nursing staff would inform the GP and the senior nurse on duty for the team. The GP would prescribe anticipatory drugs to enable the patient's symptoms to be proactively managed in a timely manner.

# Are services effective?

## Nutrition and hydration

- We observed nutrition assessment as part of the community nursing assessment tool and also as part of the pressure ulcer risk assessment. However, on a home visit to a palliative patient at the time of our inspection, eating and drinking had been identified as a problem on the initial nursing assessment but there was no evidence of a nutrition and hydration care plan in place and no additional assessment using the Malnutrition Universal Screening Tool (MUST) and management plan within the patient record.
- We reviewed an additional 21 sets of community nursing records to identify if nutritional risk was assessed on admission and found 13 had been assessed and six of the 13 had been reassessed. We reviewed a documentation audit for the Nutrition and Dietetics Nutritional Support Team completed in March 2016 which identified of the 40 records reviewed, 24 had not had their body mass index and percentage of unintentional weight loss assessed which could be done using the MUST. An action plan was identified, no date for re-audit was identified; however, we saw that this had been identified on the risk register for community health services for adults.
- Staff were aware of how to refer patients to a dietician for specialist advice.

## Technology and telemedicine

- Clinic appointments were made at health centre receptions onto an electronic system.
- Staff in the INTs had hand held devices to access the demographic details of patient, and to record their activity. The trust had continued work since our last inspection to identify an electronic patient record that was fit for purpose and this work was expected to be completed and the new electronic system was to be piloted early 2017.
- There was on going work within the trust to develop and utilise electronic applications to support patients to manage their long term condition in relation to Chronic Obstructive Pulmonary Disease.

## Patient outcomes

- The introduction of the incident review group which looked at incidents in relation to administration and

prescribing of insulin had resulted in a reduction of attributable harm to patients. There were 19 incidents deemed attributable for the period 2015 to 2016 since the introduction of the group which was a reduction of six compared to the previous year.

- For the period 1 April 2016 to 30 June 2016, of the 58 patients receiving care from the stroke service, 84% had written goals in place and 90% had a mood and anxiety screening on admission to the service for rehabilitation. Of the 54 patients discharged from the service, 95% had achieved an improvement in at least one domain on the functional independence measure (FIM) and the functional assessment measure (FAM).
- The Care Home Effective Support Service (CHESS) team supported community assessment beds in two care homes to reduce unnecessary admissions to hospital. The service worked closely with GPs, social services, care home staff, and hospital discharge planning staff and provided medication reviews, proactive screening, and therapy interventions. The service had reduced unnecessary admissions to hospital by 56% within the first six months of service. The team had implemented a 'hydration tool kit' in the care homes which had resulted in patients diagnosed as dehydrated being treated at home rather than being transferred to hospital. The toolkit had been nominated and shortlisted for a 2016 Royal College of Nursing award at the time of our inspection.
- The tissue viability and lymphoedema service had improved outcomes for patients with lymphoedema. Patients were asked a set of questions to get a baseline prior to being offered the service. An audit of nine patients, who had presented with lymphoedema, from March 2016 to August 2016, found that all experienced reduced lymphoedema following treatment, and all experienced a reduction in heaviness and aching limbs. There were six patients who stated they were experiencing pain prior to treatment and all six identified a reduction in pain following treatment.
- The diabetes service audited 30 patients who had received the service from 1 April 2016 to 30 June 2016 and found that 83% of patients were given a written care plan and 41% stated they had completed their goal with 42% completing it to some extent, and 92% of the sample stated they felt more confident to manage their diabetes.

# Are services effective?

## Competent staff

- Staff had the opportunity to enhance their knowledge through learning and observation.
- Learning needs were identified during the annual appraisal system. Staff told us there was a new appraisal system in place which had made the process easier and more meaningful.
- All staff we asked at the time of our inspection told us they had received an appraisal within 12 months prior to our inspection: However, data provided by the trust for April 2016 identified the appraisal rate for non-medical staff in community health services for adults was 53.9%, which was lower than the trust target of 85%. Eight teams across the core services did not appraise any of their staff in the 12 month period.
- Staff were supported by a local hospice where training in relation to palliative care and end of life care planning was available. In Preston and Chorley and South Ribble 176 of the 207 had attended the training for end of life care planning in the 12 months prior to our inspection. In the Blackburn with Darwen locality, eight staff had attended the training and plans were in place for these eight staff to disseminate learning to the other 62 staff.
- Case managers were being supported to complete the V300 non-medical prescribing course to enable them to prescribe medication from the national prescribing formulary. Community matrons had completed the course and community nurses were supported to complete the non-medical prescribing course to enable them, to prescribe from the nurse's formulary.
- The trust offered a number of placements annually to complete the specialist practitioner course in community nursing. The trust offered a development role for band five nurses who were considering attending the specialist practitioner course and who wanted to develop in a leadership role. This enabled staff to gain experience to underpin the university course and also assisted the trust to employ senior staff in the future.
- In the podiatry service the foot assistants were supported to complete the Care Certificate which is the minimum standards that should be covered for care workers.
- The tissue viability service provided staff with training and support in competencies in relation to wound management. Nurses in the team attended tissue viability refresher modules to maintain their knowledge and competence.
- The stroke team had a psychologist in the team who provided solution focused therapy. A band four rehabilitation assistant had been trained to deliver some psychological interventions under the supervision of the psychologist. Learning had been disseminated to all staff members and staff told us this had improved their interactions with patients.
- There was little evidence of any one to one meetings documented within the INTs; however, staff could raise issues during the daily handovers, team meetings or could request a meeting with their manager.
- The trust had a policy in place to provide clinical supervision for staff and the trust target was to attend at least four sessions annually. The data provided by the trust for community health services for adults identified that of the 51 teams identified across the localities, 37 had achieved 100% compliance for clinical supervision. The remaining 14 team's compliance ranged between 30% and 90% with the North INT and out of hours service at Blackburn with Darwen achieving less than 50% compliance.
- The trust had an induction process for new staff and a preceptorship programme in place for newly qualified nurses. Within these processes, there were competencies for staff to meet and have signed off.
- The trust had a process in place to manage poor performance to support staff to improve.
- Staff could access 10 different pressure ulcer modules via the trust training tracker. Staff training requirements are determined on prior experience, competence and job/role requirements. In total the service had highlighted 414 people who required some form of pressure ulcer management training. All have accessed the training tracker to complete a minimum of one module. In the 12 months prior to September 2016, 139 people have accessed pressure ulcer training modules via training tracker and completed various modules dependent on individual role requirements. This equates to 33.6% of staff identified.

# Are services effective?

## Multi-disciplinary working and coordinated care pathways

- Therapy, nursing and specialist teams worked together to provide care to patients. There was no clear documentation in any of the records we viewed that identified who the professional was that was leading on a patient's care.
- Case managers were employed on some hospital wards which maintained good links with community staff. A process was in place for referring the patients requiring care after discharge and planning commenced at the earliest opportunity.
- Staff were able to attend meetings at GP practices where patient's ongoing needs were discussed and plans for patients approaching end of life were agreed.
- The community matron service had been disbanded in the Blackburn with Darwen locality and the role of the case manager had been introduced to provide complex case management as part of the intensive home support service. This had resulted in therapy, nursing and social services working more closely together to support the patient's pathway during periods of crisis.
- There was close working relationships between community nursing, treatment room services and podiatry services. The tissue viability team worked closely with community nurses to provide advice and support in relation to wound care and provided joint visits to patients with complex wounds.
- There were links between the discharge planning team based at a local hospital trust for people being discharged from hospital. Nursing staff reported having good communication links with the team and that the service implemented plans within a few hours when patients who were approaching the end of their life needed to be fast tracked home.
- There was evidence of joint working between the diabetic service and a local ambulance trust on a hypoglycaemia pathway. Patients who contacted the local ambulance trust were referred to the diabetes team for face to face advice and treatment. As a result of the auditing of these patients, staff identified an increase in falls in older patients with diabetes and the service was reviewing improved ways to manage these patients.

## Referral, transfer, discharge and transition

- Community services used a central point for making referrals. This was the Main Access Point (MAP) for Chorley and Preston locality, and the Single Point of Access (SPA) for the Blackburn with Darwen locality. This service was operational 24 hours a day, seven days a week. Administration staff operated the service Monday to Friday during office hours and during out of hours, evenings and weekends, the community staff could access the referrals. Staff reported that the process worked quickly and effectively.
- Referrals to the MAP and SPA were made via facsimile and this could be switched to a manual fax function if there was an issue and the IT system failed.
- Staff from the discharge planning team strived to ensure people being discharged home from hospital had appropriate nursing care and support in the community

## Access to information

- Referrals were sent from the SPA to the community health services for adults.
- Patient information was shared across community adult services and was paper based.
- Information and policy guidelines were accessible to staff via the trust intranet.
- Patient demographic information and visiting schedules were held on the electronic record which staff could access.
- Staff in the integrated nursing teams had access to hand held devices where they could view the list of patients they were allocated whilst out of the office.
- Patients could self-refer to the tissue viability service if they have received care from them previously.

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

- As part of the trust mandatory training, staff received training for Deprivation of Liberty Safeguards, and Mental Capacity Act (MCA). At September 2016 the community health services for adults was 82.2% compliant with level one MCA and 42.1% compliant with MCA level 2. This was less than 75% compliance with for level two MCA training.

## Are services effective?

- There were safeguarding and mental capacity champions within clinic settings and there was a checklist available to staff in relation to assessing capacity.
- Where required, nursing staff used a template to complete details about mental capacity. Best interest decisions were made in consultation with other healthcare professionals and family members. Staff knew who to ask if they had queries about this element of care. We reviewed 32 records to determine if a patient's capacity was clearly identified and found it was in 19 of the records.
- Staff we spoke with understood patient consent and when it should be obtained.
- We observed staff gaining implied consent which is permission for healthcare without a formal agreement between patient and health care provider, however we did not see this documented in patient records. Of the ten documentation audits we reviewed five audits included 'Evidence of appropriate consent being sought' however this part of the audit had not been completed in all the audits and we were not assured that documentation of consent formed part of the audit process.
- We reviewed four sets of records from services which included heart failure service, COPD service and pulmonary rehabilitation service and found no record of consent documented in the four records. We asked staff why consent was not documented and were told that implied consent was taken but not documented.
- We requested data from the trust to demonstrate how consent to treatment was audited. The trust provided data for older people's mental health inpatients only so we were not assured that this was audited in the services we inspected.



## Are services caring?

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

### Summary

We rated community health services for adults as 'good' for caring because:

- People were treated with dignity and respect during interactions with staff.
- Staff were compassionate and supported people and those close to them to manage their condition.
- Staff explained treatment and interacted well with patients. We observed this during home visits and patients receiving care in the clinic setting.
- People were able to ask questions, discuss care and were involved with decision making.
- The services received positive comments about the staff and the care provided.
- Services worked with other agencies and providers of care to ensure all patients' needs were being met.

### Compassionate care

- We observed care being delivered with empathy and compassion. All interactions we observed between staff and patients at the time of our inspection were provided in a caring manner with a good rapport with patients.
- We observed patients in treatment rooms having their privacy and dignity maintained by being treated in a private area.
- All of the staff we spoke with demonstrated a passion for delivering good care to patients.
- Patients were treated as individuals and staff respected patient's personal decisions about their care.
- Clinic reception staff were friendly and welcoming when patients arrived. In the Leyland clinic the reception staff had created a notice board with photographs of their pets. Staff told us patients liked this and it generated conversations with them.
- We observed a home visit where a palliative patient became upset and observed the nurse actively listening to the patient, demonstrating empathy and taking action to resolve the issues of concern for the patient.

- All staff we asked told us that patients who were approaching the end of their life were dealt with as a priority if they contacted the service requiring symptom management. This was evidenced in the patient records that we reviewed. Staff told us they were proud of the care they delivered to patients approaching end of life.
- At the time of our inspection patients we spoke with told us 'staff are very caring and very respectful'.
- At the time of our inspection a patient told us 'I feel comfortable knowing that I can ring for help and advice and can be seen on the same day if needed'.
- At bases we visited we observed thank you cards from patients who had received services.
- A patient receiving care from the tissue viability and lymphoedema service described staff as 'informative and friendly, you feel as if you matter'.

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

- Patients receiving care in treatment rooms were observed asking questions, discussing care and were involved with decision-making about their care.
- All staff we asked told us they worked with patients and those close to them, ensuring they understood the care being provided.
- Meetings were held for patients with complex needs being discharged home from hospital with a requirement for nursing care. Those close to the patient were invited to attend these meetings to be involved in decisions made.
- We found that discussions with families for patients who were approaching end of life were not always documented in the patient record. In the 20 records we reviewed this was documented in ten records.
- At the time of our inspection patients and their carers told us 'we feel listened to', and they said they were 'given options of care which is appreciated'.
- An audit performed to gain feedback from patients following a diabetic foot review 40 out of 45 patients stated they would recommend the service.

## Are services caring?

- Where carers were actively involved in patient care, staff supported them and provided them with information.

### Emotional support

- In relation to privacy, dignity and wellbeing, the 2016 Patient Led Assessment of the Care Environment (PLACE) score for the trust was 86%, which was the same as the England average
- During a home visit with a community nurse, we observed the nurse supporting and advising a patient and their carers in relation to issues they raised at the visit.

- Staff told us they offered support to service users especially when providing palliative care and arranged additional support visits, where required.
- Community nurses worked with voluntary agencies to arrange additional care for palliative care patients which included voluntary staff staying at the patient's home for an agreed time to allow carers time to rest or to go out of the home knowing that the patient was not left on their own.

# 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 community health services for adults as 'good' for responsive because:

- Referrals to services were prioritised to ensure patients with urgent need were seen in a timely manner. There was easy access to clinic premises and the referral process took into consideration the holistic needs of people using the services. We saw evidence of flexibility to meet patients' needs which included: rehabilitation services being offered in the workplace.
- Patients referred to the stroke service were contacted within 72 hours of referral in line with best practice guidelines.
- People who used services were given information on how to complain or compliment services: complaints were disseminated to staff via team meetings and any lessons learned were shared.
- There was evidence of delivering services to meet patients' needs. There had been a review of the community matron service which identified the need for specialist Chronic Obstructive Pulmonary Disease (COPD) services and rapid access to care to prevent hospital admissions. There was evidence of multi-agency and patient focus groups to inform the delivery of services which resulted in a more integrated approach to service delivery via the intensive home support service.
- Staff in the diabetes service could deliver training in additional languages and translators were available to support training sessions for patients whose first language was not English.
- Podiatry services had implemented a one stop assessment for patients who may require nail surgery which resulted in a reduction of additional appointments for patients and an increase in podiatry staff availability. The service had direct access to a vascular surgeon where they could arrange urgent appointments and the service could order diagnostic tests prior to the patient attending the appointment to enable the consultant to have sight of all information at the time of consultation.

However;

- Informal complaints were not reported or monitored and were resolved at local service level. This resulted in not all complaints being recorded and monitored which could have a negative impact on services learning from complaints.
- No formal audit was undertaken of response times for integrated nursing teams. Response times formed part of the patient's pathway of care in accordance with their need.
- The integrated nursing teams were not recording the reason for cancelled appointments.

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

- Therapy and nursing staff provided care in patients' own homes if they were housebound and unable to attend a clinic session.
- Treatment room sessions and clinic based services were offered at health centres across the localities for easy access for patients.
- The podiatry service at the Minerva Centre provided transport for patients with limited mobility.
- Staff had access to members of the multi-disciplinary services within the community and the local hospital and were able to refer patients to the services to meet patient's needs.
- There had been a review of the community matron service in Blackburn with Darwen which identified the need for specialist Chronic Obstructive Pulmonary Disease (COPD) services and rapid access of care to prevent hospital admissions. There was evidence of multi-agency working and consultation and input from patient focus groups to inform delivery of services. Blackburn with Darwen locality had implemented an intensive home support service that consisted of rapid assessment, intra-venous service, COPD service and complex case management. An electronic referral had been developed and had improved the referral process.

## Are services responsive to people's needs?

- The Care Home Effective Support Service (CHESS) team were proactively working with care home staff and the local authority to reduce unnecessary admissions to hospital and had introduced a hydration tool kit to treat patients in their own home if they became dehydrated.
- The discharge planning team based at a local hospital worked with community services and hospital teams to support patients who were approaching end of life and had expressed a wish to die at home. Patients were fast tracked out into the community with the correct services and equipment. We observed a patient story which identified at 12.00 midday a patient wanted to be discharged home to die. Plans were put in place and they arrived home at 17.30 in the afternoon and subsequently died later that evening.
- The tissue viability and lymphoedema service worked together with a specialist podiatrist to provide a 'healthy legs clinic' in Darwen based on a social care model in sheltered accommodation. Patients could drop in for advice and be measured and prescribed appropriate support garments.
- Assessments and rehabilitation for stroke patients were conducted in a variety of settings. Staff gave an example of a patient who could manage at home as they lived in a bungalow but needed support in the work place. Therefore, staff conducted the patient's therapy in their place of work.
- At the Minerva Centre larger treatment couches were available for bariatric patients.
- The discharge planning team were proactively monitoring and liaising between hospital and community services to highlight and reduce the incidence of delayed episodes of care when patients were discharged back into the community from hospital.

### Equality and diversity

- Staff could access interpreter services for patients whose first language was not English. Leaflets were available in a variety of languages, if required.
- Clinics and health centres we visited at the time of our inspection were accessible to disabled patients.
- The diabetes service delivered teaching sessions to patients in English and additional languages, and

translators could also be utilised during teaching sessions. The service provided sessions during Ramadan to discuss risks and management of such risks during periods of fasting.

### Meeting the needs of people in vulnerable circumstances

- Care was provided for people in vulnerable circumstances. Staff received training on how to safeguard children and adults which was monitored. Staff explained how they worked in the best interests of patients and, where necessary, consulted with those close to them.
- Staff worked closely with carers of patients that had learning difficulties to ensure their needs were met.
- Community clinics where the adult community services provided care were not assessed as part of the Patient Led Assessment of the Care Environment to determine if clinics were dementia and we don't not see dementia training as part of the core mandatory training.
- The communicable disease service met with communities at risk to increase uptake of vaccines and were working with refugee groups.

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

- The timescale to first visit from the integrated nursing service was completed by the referrer and was determined by clinical need. Therefore, the first visit following a new referral varied from a few hours to a number of weeks. First visits were undertaken on this basis and subsequent visits were planned based upon the needs of each patient. First visits were not classified as urgent or routine. If there was an urgent request from a patient, carer or referrer, the trust told us that nurses responded within a four hour timescale; however, this was not audited or monitored. Customer care monitoring had not identified response times raising cause for concern for users of the service.
- For the period 1 April 2016 to 30 June 2016, the integrated nursing services in each locality were collectively over performing against their contract for activity. Preston locality was performing slightly less than the contract with Chorley and South Ribble, and

## Are services responsive to people's needs?

Blackburn with Darwen performing more activity. For this period the service were commissioned to achieve 107,625 contacts and had achieved 116,432 with 87% of the contacts being face to face with the patient.

- For the period 1 April 2016 to 30 June 2016, 53 out of 54 patients referred to the stroke service were contacted within 72 hours of referral which met best practice standards.
- The adult community services performed 393,994 appointments between 1 April 2016 and 30 June 2016, with 4926 appointments cancelled by the services and 5636 cancelled by the patient. Of the 4926 which equated to 1.3%, appointments cancelled by the services, 3161 were cancelled by the integrated nursing service; however, the reason for cancellation had not been recorded.
- Did not attend rates in communicable disease clinics reduced from 55 % to 2% during the period April 2015 to March 2016 by the service implementing changes to how they delivered the service.
- We reviewed the utilisation of treatment room appointments for the period August 2015 to July 2016 and found Blackburn with Darwen had utilised 85.4% of appointment slots and Central Lancashire had utilised 88.7 % of appointment slots: however, this data was taken from the Information Patient Management (IPM) booking system and there were a number of treatment rooms in Central Lancashire that were not on IPM and therefore not included in this report. There was a plan to move all treatment rooms in the central locality onto IPM from October 2016.
- The chronic fatigue service were meeting the referral to treatment time of 18 weeks at March 2016 and had no patients waiting over 18 weeks from 14 June 2016 to 26 July 2016; however, they discontinued taking referrals in July 2016 due to the service being decommissioned and due to cease in October 2016.
- At the time of our last inspection we found there were long waiting times for patients attending the podiatry service at Leyland clinic. The service had developed a one stop appointment for patients who required potential nail surgery. Patients could attend for assessment and, if required, could choose to have surgery at the same appointment. This had reduced the number of appointments for the patient and had saved

36.5 podiatry hours in the first two months of implementation. We reviewed data provided by the trust which identified for the period 4 January 2016 to the 22 August 2016 there were no patients waiting for reassessment at the Minerva centre.

- The podiatrists could request a range of diagnostic tests and had access to the vascular consultant's diary to book urgent appointments for patients. Podiatry had daily access to a vascular consultant who could see patient the same day. The service was able to generate a letter for the patient to take with them to the appointment with basic blood tests and x-rays completed before the appointment.
- The complex case managers in Blackburn with Darwen had a two hour response time to referrals received by a local medical service during the hours of 8am to 6pm seven days a week. The trust provided information that stated that the local medical service reported to the commissioners on response times and that 85% of patients were seen within the two hour timeframe: however, we were not provided with the report, the timeframe or the numbers included and therefore, we were not assured that the response times reported on were for the actual case managers. The trust did provide us with a snapshot of nine referrals received between 6 June 2016 and 21 June 2016 and, of the nine referrals received during the hours of 8am to 6pm, eight referrals were suitable to receive the service, and three of these were not seen within the two hour response time.
- We observed that carers were given written information leaflets in relation to preventing pressure area damage.

### Learning from complaints and concerns

- A trust wide policy included information on how people could raise concerns, complaints, comments and compliments. Community health services for adults provided patients and their families with feedback forms at home visits which they could complete and send by freepost to the Patient Advice and Liaison Service (PALS).
- Information was displayed in clinics about how patients and their families could complain.

## Are services responsive to people's needs?

- Initial complaints were dealt with by team leaders in an attempt to resolve issues locally. If this was unsuccessful the complaint was escalated for further investigation; however, the informal complaints were not monitored to identify any trends or themes.
- Staff we spoke with were aware of the complaints procedure and told us information about complaints was discussed in team meetings.
- Information regarding complaints was submitted monthly to the Quality and Safety Sub-committee.
- The adult community services received 128 complaints with 22 complaints withdrawn, 28 not upheld, 43 partially upheld and 35 upheld .
- No complaints were referred to the Parliamentary Health and Social care Ombudsman.
- The podiatry team had the highest number of complaints with 33. Waiting times for appointments were raised as a concern; however, the service had been through a restructure in the 12 months prior to our inspection and changes had been implemented to improve access to the service.
- The core service received 2,981 compliments

## 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 community health services for adults as ‘good’ for well-led because,

- There was a clear vision and set of values which was visible in the places we visited. Staff were engaged in the vision and values and told us these formed part of their annual appraisal.
- There was a clear organisation structure for the community health services for adults with clear lines of responsibility and reporting.
- Staff felt supported and listened too and there were professional forums for nurses and allied health professionals.
- Staff were able to discuss changes to practice that would improve services and got support to implement them. We saw evidence of this within the podiatry services and the introduction of a one stop assessment process for patients who may require nail surgery.
- There was interaction between the executive team and services via the implementation of the ‘Good Practice Visit’ where good practice and quality improvements were recognised and recommendations were made to the service via a structured feedback process.

However:

- We observed strong leadership from team leaders and managers in most of the areas we visited however there was some lack of knowledge on current systems and processes that were in place.
- Risk registers were held on the electronic system; team leaders had access to the risk registers, and could discuss adding risks to the register with their managers. However, we identified the lack of the use of end of life care plans not identified on the community health services for adults risk register.
- Band five staff in the integrated nursing teams did not know what patient outcomes they were achieving and could not tell us outcomes from the safety thermometer.

- We were not assured that lone working systems in place were always completed to ensure staff working on their own in the evening had finished their shift and were safe.

### Service vision and strategy

- The trust’s vision was to provide “High quality care, in the right place, at the right time, every time”.
- The service was following the trust vision and staff we spoke with were aware of the vision and could describe the trust values of “Teamwork, Compassion, Integrity, Respect, Excellence and Accountability”. The trust values were assessed as part of the staff appraisal process.
- At the time of our inspection we observed the trust’s vision and values displayed in the health centres we visited across all localities.
- The Strategic Plan 2014/19 underpinned the trust’s vision and was made up of six priority areas including: to provide high quality services, to provide accessible services delivering commissioned outputs and outcomes and to innovate and exploit technology to transform.
- Progress against the strategy was reviewed and monitored and included recognising challenges, opportunities and achievements.

### Governance, risk management and quality measurement

- There were clear lines of responsibility within the organisational structure of the service, professional leads for professional disciplines and staff we spoke to at service level were aware of their responsibilities.
- The community health services for adults held a risk register. We reviewed the risk register in place at 6 September 2016 and saw risks identified which included: mandatory training compliance, clinicians not receiving professional specific supervision, lack of care planning and robust records for patients attending podiatry due to the restructure of the service, staff appraisal compliance, nutrition and dietetics

## Are services well-led?

documentation, pressure ulcer report review response times, pressure to services due to increasing numbers of patients approaching end of life. Risks had a risk scoring ranging from four to 20 and there was a nominated person responsible for the risk.

- Data provided by the trust included an Assurance Report for Pressure Ulcers Serious Incident Reviews however; the report was not dated so we were unclear how relevant it was. The report was to provide assurance to commissioners in relation to improving care in the management of pressure ulcers due to the common themes emerging from incidents. The report outlined future areas to continue to improve which included improvements with completing body maps and photographs and compliance against training.
- The report also highlighted that the network risk register holds a risk scoring at 20, but due to reporting and assurance system improvement through the work of the skin care group, this risk was dropped to a score of 15, allowing continued awareness of the executive team and the board assurance framework. We reviewed the community health services for adults risk register for September 2016 and found there were risks on the register with scores ranging from four to 20. There was a risk specifically relating to pressure ulcers scoring 12 at the time of the inspection.
- We observed minutes for a Quality Group Meeting held in August 2016 that identified an emerging risk with compliance to NICE Guidelines in relation to end of life care: However, there was no risk identified on the risk register in relation to not meeting NICE Guidance for end of life care.
- The service had re-audited standards against NICE Guidelines for end of life care in April 2016 due to a previous audit in October 2015 identifying a lack of compliance. The audit identified there remained a lack of compliance however, there was no action plans identified and no plan to re-audit due to the implementation of the new end of life/individualised care plan on 1 August 2016. We did not see as part of the auditing process how the new care plan had been audited to determine if it was fit for purpose and when we asked managers there were no plans in place to audit this.

- The Clinical Director for the community health services for adults provided a monthly quality and performance report to the quality and safety sub-committee. This was to provide executive scrutiny of incidents, complaints and lessons learned as well as compliance with mandatory training.

### Leadership of this service

- An organisational structure was in place for the community health services for adults. There were clear lines of responsibility, which was headed by a network leadership team which consisted of a Clinical Director and a deputy Clinical Director. There were professional leads for each of the professional disciplines within the service.
- Daily management of services was delegated to team leaders.
- Integrated care meetings took place across the localities. Blackburn with Darwen had implemented a weekly Skype meeting with nurses from the INTs, voluntary agencies and the local authority. Other localities attended meetings at GP practices to discuss patients with complex needs and patients approaching end of life.
- Band six and seven nursing staff attended professional forums monthly and described the forum as an excellent resource.
- The trust was supporting staff with the revalidation process and information was available on the intranet.
- Teams we inspected held team meetings to ensure staff received information and feedback regarding incidents and complaints and to keep staff informed of developments within the trust.
- We saw evidence that executive walkabouts took place in the form of a 'Good Practice Visit'. We observed the feedback from a visit to the community neurological rehabilitation service on 5 April 2016 which identified good practice and service improvement and highlighted recommendations for the service to consider.
- Band five staff in the INTs did not know what patient outcomes they were achieving and could not tell us outcomes from the safety thermometer.
- We observed strong leadership from team leaders and managers in most areas we visited and staff spoke



## Are services well-led?

positively about the team leaders, describing them as visible, accessible and supportive. We found there was some lack of knowledge on current processes and systems within the leadership team at the time of our inspection.

- We were told by staff in INTs that daily handover meetings were in place, we observed a meeting taking place in one INT however, and the times that we visited sites were not at the time handovers were held at the time of our inspection. We asked to see evidence of handovers however, there were no handover sheets or a record of the discussions recorded.

### Culture within this service

- There was a positive culture within the community health services for adults and we observed good team working in all the areas we visited.
- Teams were proud of the service they provided and how they worked together to support each other.
- Staff told us they felt listened to and supported by their managers and team leaders.
- The trust had a lone working policy and all staff had a mobile phone provided by the service. There were local arrangements in place for services to ensure their staff were safe. INTs were able to see where staff were visiting and where they had visited on a daily basis on the electronic system. However, there was no way of accessing this information if the electronic system was to fail. The electronic system had been identified as a risk on the trust's risk register.
- Staff we spoke with were able to describe the process for escalating a concern if a staff member was unable to be located which was in line with the trust's lone worker policy. Staff at bases were aware of, and were able to show us a register containing staff contact details and vehicle descriptions and registrations.
- Staff working on the twilight shift in Chorley and South Ribble worked alone until 10pm in the evening with a band six staff member available at a base that could be contacted and could monitor where staff had visited. We were told there was a system to record that staff were on duty and to mark staff as safe at the end of the shift. We reviewed these records from 2 September 2016 to the 11 September 2016 and 1 August 2016 to the 5 August 2016, and found on 16 occasions out of a possible 45

where all staff were not identified as finishing their shift. However, there were no incidents reported of this nature and staff on duty told us it was likely they had contacted the base to say they were safe and going off shift but this had not been checked off on the sheets. We were not assured that lone working systems in place were consistent to ensure staff working in the evenings on home visits was safe.

- The stroke and neurological rehabilitation team had a signing in and out sheet which we observed at the time of our visit and all visits were viewable on the electronic system. The service had a code word that could be used to alert other staff members discreetly if they were in danger. The rapid assessment service always sent two staff on initial visits to patient's homes.

### Public engagement

- The trust used the NHS Friends and Family test. In August 2016, 97.1% of service users that responded said they were likely or extremely likely to recommend the service and throughout 2016 the average response was 92.2%.
- A patient group had been involved in discussions to improve the services to patients in a crisis and the development of the intensive home support team.

### Staff engagement

- Staff received a weekly trust wide newsletter by email informing of organisational developments and attended monthly team meetings. A "Dear David" initiative was in place to allow staff to contact a member of the board directly to raise any concerns.
- Staff engagement events took place to capture staff views and annual staff awards took place to recognise work to improve experiences for service users and their families.
- Results of the 2015 NHS Staff Survey showed the trust performed better than the national average for combined mental health/learning disability and community trusts in the areas of staff satisfaction with the quality of work and patient care they were able to deliver, staff motivation at work and recognition and value of staff by managers and the organisation. Data could not be disaggregated for staff specifically working in the community health services for adults.

## Are services well-led?

- Physical and psychological support services were available to staff and staff were aware of how to access them.

### **Innovation, improvement and sustainability**

- The podiatry service had daily access to a vascular consultant who could see patients the same day. The service was able to generate a letter for the patient to take with them to the appointment and was able to request basic blood tests and x-rays prior to the appointment. This reduced the need for additional appointments for the patient and provided the vascular consultant with all the information required to inform future care planning.
- Joint working between the diabetes service and a local ambulance trust to support diabetic patients on a hypoglycaemia pathway, had identified an increased risk of falls for this group of patients. The services were working together to improve management for these patients.
- The tissue viability and lymphoedema service working with a specialist podiatrist were running a 'healthy legs clinic' in Darwen twice weekly based on a social care model in sheltered accommodation. Patients could drop in for advice and be measured and prescribed appropriate support garments.
- The CHES team were working closely with care home staff and had reduced unnecessary admissions to hospital and had implemented a 'hydration kit' for which they had been nominated for an award by the Royal College of Nursing.
- The trust had identified the recruitment of senior nurses as a risk within the INTs. The service had implemented a development role for band five staff that were considering a leadership role and undertake the specialist practitioner in community nursing training at university. This role had given staff an insight into the role and gave them experience prior to attending the university course. Staff we spoke with that had completed the development role prior to attending university had welcomed the opportunity and felt that it had given them experience to underpin the university course.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>How the regulation was not being met:</b></p> <p>The provider did not do all that was reasonably practicable to mitigate the risks of patients developing pressure ulcers on their caseload.</p> <p><b>This is because;</b></p> <ul style="list-style-type: none"><li>• There were a high number of patients developing pressure ulcers on the service caseloads.</li><li>• Risk assessments and care plans were not always fully completed or reviewed.</li><li>• Poor staff compliance with pressure ulcer training provided by the trust.</li><li>• Documentation was highlighted as requiring improvement in the root cause analysis investigations we reviewed however, the integrated nursing teams had not performed a documentation audit in the 12 months prior to our inspection.</li></ul> <p><b>This is a breach of Regulation 12 (1) (2) (a) (b) (c)</b></p>