Buckinghamshire Healthcare NHS Trust

RXQ

Community health services for adults

Quality Report

Queen Alexandra Road
High Wycombe
Buckinghamshire
HP11 2TT
Tel:01494 526161
Website: www.buckshealthcare.nhs.uk

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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)
RXQX5	Buckinghamshire Healthcare NHS Trust		
RXQ51	Amersham Community Hospital		
RXQ65	Marlow Community Hospital		
RXQ62	Thame Community Hospital		
RXQX1	Rayners Hedge		
RXQX3	Chalfonts and Gerrards Cross Community Hospital		

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall this core service was rated as 'requires improvement'. We found that community health services for adults were 'good' for effective and caring services but 'required improvement' to be a safe, responsive and well led service.

Our key findings are:

- Incidents and near misses were not always reported. There was a lack of clarity about who would report an incident which occurred during a home visit or in a community based clinic. Many staff were not aware of the requirements of the Duty of Candour in handling incidents.
- There were significant staffing shortages in many of the community services we visited, with particular shortages of nurses, physiotherapists and occupational therapists. Staff told us that as a result of staff shortages there were waiting lists for some services and that other services were scaled back. There were many examples of this. Staff told us there was a 14–16 week wait for patients to access services at the Thame Day Hospital because there were insufficient staff to provide the service. The pulmonary rehabilitation clinic we visited was short of a physiotherapist and staff told us this had contributed to a delay in providing one of the service's scheduled rehabilitation programmes. Staff at the Drake Day Hospital told us they prioritised the most complex patients, for example those patients requiring neuro-rehabilitation, and that other patients could not be treated because there were not enough occupational therapists.
- Facilities we visited were clean and hygienic. Trust premises and community locations were generally well maintained although facilities for the head injury service in Cambourne required review. Equipment was available for patients in their homes and was usually delivered promptly, although there were some problems in delivering non-urgent equipment, which were being discussed with the equipment provider. Electronic patient record keeping systems were not often linked together, which meant that some services could not access information about patients which was held by other services.
- Staff across all services described anticipated risks and how these were dealt with. Lone working policies were in place but community staff did not feel these addressed their specific working conditions. Safeguarding protocols were in place and staff were familiar with these. Staff were able to describe the types of major incidents in which they could potentially be involved and the system for responding to major incidents.
- Community services took into account guidance from the National Institute for Health and Care Excellence (NICE). There was well established multidisciplinary team working across almost all the community services we visited, although further work was required to clarify referral criteria between services. Staff had statutory and mandatory training, and described good access to professional development opportunities. However, training in and understanding of the Mental Capacity Act 2005 was variable.
- Patient outcomes were monitored but were aggregated with divisional level data which included data from acute and community services. There were limited systems in place to monitor the performance of community services specifically. Data provided by the trust covering the period January 2014 to January 2015 suggested improving outcomes for patients. Incidents of pressure ulcers varied throughout the period and a plan was in progress to address this.
- Patient feedback was collected and used in planning many of the services we visited, most frequently through surveys or focus groups. Feedback from patient surveys shown to us by trust staff was, almost without exception, positive. Lessons from incidents and complaints were usually shared within the services in which they occurred, but lessons learned from other services within the trust were not routinely communicated.
- We found staff were caring and compassionate. Without exception, patients we spoke with praised staff for their empathy, kindness and caring. Some patients described what they felt were examples of staff going above and beyond the requirements of their job in order to ensure their wellbeing. There were

programmes aimed at meeting the needs of specific communities, for example, a drop-in programme run by the diabetes team for patients over Ramadan to help them make adjustments to their medication while fasting.

- Most staff we spoke with felt they could discuss concerns with their line manager but many felt the trust's senior management could do more to involve them in discussions which affected community services. Community staff felt that trust-wide governance and leadership arrangements lacked sufficient consideration and understanding of community services. Staff identified the availability of community services and referral criteria as being key areas for improvement, as well as training, and policies and procedures that needed to better reflect the context in which community staff worked.
- Performance indicators were used by management to monitor the quality of community services, but performance outcome data for community services only were limited. For example, the community services quality dashboard combined data from all seven community localities and it was not possible to review results by individual adult community healthcare team. Where outcome data was available for community services, they were usually aggregated with patient outcome data from the trust's acute services.
- Elements of the trust's vision and strategic forward plan had been or were being implemented in relation to adult community services. Staff were focused on achieving key outcomes and these were linked to the trust's vision and strategy. Trust management recognised concerns about the sustainability of current staffing levels and described initiatives to address this.
- There was a clearly embedded ethos of improvement and innovation in some services. This was particularly the case in cardiac rehabilitation and respiratory services, the chronic fatigue and pain management services, and the community diabetes service.

Summary of findings

Background to the service

Background to the service

Buckinghamshire NHS Trust offers a range of acute and community services, and is the main provider of community services across Buckinghamshire.

Adult community services are provided through a network of seven locality based adult community healthcare teams (ACHTs) and by community teams based at a number of locations throughout Buckinghamshire. These include teams in Winslow, Aylesbury, Thame, Wycombe, Marlow, South Bucks and Amersham. Services are provided in trust facilities, people's own homes, clinics, community centres and GP practices.

The trust provides adult community services to support people in staying healthy, to help them manage their long-term conditions, to avoid hospital admission, and following discharge from hospital to support them at home.

Adult community services includes:

- District nursing, with a scaled down service at night.
- Physiotherapy and occupational health teams.
- Specialist nursing services.
- Integrated stroke and respiratory services.
- Integrated falls and bone health services.
- Diabetes education and advice.
- Rehabilitation and intermediate care.
- Chronic pain and Chronic fatigue management.
- Neurological rehabilitation.
- Continence services.

Community services work closely with acute services, commissioners, adult social care services and GPs.

Our inspection team

Our inspection team was led by:

Chair: Mike Lambert, Consultant in Clinical Effectiveness, and formerly Emergency Medicine, Norfolk and Norwich University Hospital

Head of Hospital Inspection: Joyce Frederick, Head of Hospital Inspections, Care Quality Commission (CQC)

The team of 35 included CQC inspection managers and inspectors. They were supported by specialist advisors, including health visitors, a school nurse, a physiotherapist, an occupational therapist, district nurses, registered nurses, a continence specialist nurse, a paediatrician, a GP, a pharmacist, safeguarding leads, a palliative care consultant and palliative care nurses. Three exerts by experience who had used the service were also part of the team. The team was supported by an inspection planner and an analyst.

The team that inspected adult community healthcare services included CQC inspection managers and inspectors, as well as two experts by experience (people who use services), a pharmacist and a variety of specialists: community nurses, occupational therapists, physiotherapists, a GP and a continence specialist nurse.

Why we carried out this inspection

We inspected this core service as part of a community inspection.

Buckinghamshire Healthcare NHS Trust had a comprehensive inspection of its services in March 2014. However, its community services were not inspected at that time. We therefore completed the inspection of its community services.

Summary of findings

How we carried out this inspection

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

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

Before visiting Buckinghamshire Health NHS Trust, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 25, 26, and 27 March 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 10 and 11 April 2015.

For this core service we visited a range of services including adult community healthcare teams, integrated cardiac and respiratory services, neuro-rehabilitation and head injury services, chronic pain and fatigue management, a continence service, the emergency assessment care team (REACT), day hospitals, diabetes services and specialist nursing services, balance classes, a wood working group, and rehabilitation clinics.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, healthcare assistants, therapists and managers. We spoke with 126 staff and one volunteer. We talked with 111 people who use services as well as carers and family members. We observed how people were being cared for and accompanied staff on eight home visits across the county. We reviewed 23 care or treatment records of people who use services.

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Summary of findings

What people who use the provider say

We spoke with 111 patients and carers covering all the adult community services we visited. We spoke with patients in clinics, at rehabilitation classes, by visiting them at home, and on the telephone. With few exceptions, patients and carers were pleased with the services they received and praised the professionalism of trust staff. They said staff were caring and supportive.

Patients and carers we spoke with felt involved in their care. They told us they were encouraged to set goals as part of their treatment plans and felt the goals they set were specific to their needs and circumstances. Patients told us staff reviewed their goals with them and provided encouragement if they were unable to meet their goals.

Patients we spoke with told us of actions that had been taken as a result of risk assessment, for example, equipment they received at home, further advice or treatment, or referral to another service. They said the carers' needs were also assessed and some patients could provide examples of care and support given to their carer as a result of such assessments.

Patients said they were given sufficient verbal and written information about their care and treatment. When they had questions, patients said staff answered these and provided clear explanations.

Good practice

- Community adult health services were available to patients 24 hours a day, seven days a week. This included nurses caring for patients in their homes at night.
- In the integrated cardiac rehabilitation service, new technology was used to improve pathway tracking of patients and provide outcome data. Staff told us the information generated as a result of this project helped them to improve the services they offered to patients. The new systems and technology, they said, had improved uptake of treatment from 52% to 82%.
- The trust provided a community diabetic service which offered two hour clinics twice a week for non-English speaking patients, and provided interpreters. Clinics could be accessed by appointment or drop in. There was also a three week education session provided over Ramadan for healthcare professionals and a drop-in programme for patients who had diabetes to help patients make adjustments to their medication while fasting.
- Staff from the respiratory team told us there was a single point of access seven days a week for specialist nursing services provided by their team. Patients, GPs, community nurses and staff from the hospital's inpatient wards could ring the team on a dedicated phone number for advice and support.
- Patients were given an individualised, multidisciplinary risk assessment regardless of the service they used. For example, patients had assessments as required for mobility, nutrition, pressure ulcers, mental and emotional wellness, occupational therapy, and home environment. We saw evidence of this in almost all the patient records we looked at.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

The trust MUST ensure

- There are effective operation of systems designed to enable it to identify, assess and manage risks relating to patients which arise from incidents and near misses.
- There are sufficient numbers of suitably qualified staff in all community teams and ensure safe caseload levels.

Summary of findings

- The suitability of premises and facilities for the head injuries unit in Cambourne.
- There are suitable arrangements for the privacy and dignity of patients using the multidisciplinary day assessment service (MuDAS).
- Patients are protected against the risks of unsafe or inappropriate care and treatment arising from inaccurate patient records or records which cannot be located promptly when required.
- Staff receive appropriate training on the Duty of Candour and the Mental Capacity Act 2005.
- Community staff and managers have clinical supervision and support to undertake their role.

Action the trust SHOULD take to improve

The trust SHOULD ensure

- The timely delivery of specialist equipment to patients.
- Information about its referral criteria to community services is clarified and promoted.
- Community staff are engaged in developing policies and procedures, and in making decisions which affect them.
- A reporting structure is developed to enable it to review the effectiveness of community services.
- Emergency resuscitation equipment is regularly checked and available for use, in all locations.
- Lessons learned from incidents and complaints are shared across services and improve access to current arrangements for sharing lessons via video link.

Buckinghamshire Healthcare NHS 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

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safety as 'requires improvement'.

Incidents and near misses were not always reported by staff. Many of the staff we spoke with were not sure of the trust's definition of a reportable incident. There was a lack of clarity about who would report an incident which occurred during a home visit or in a community based clinic. Staff did not always report delays from lack of capacity in community teams, premature discharges, or staffing shortages as incidents. Failure to report these as incidents put the trust at risk of not being able to adequately assess the impact of these issues on service provision and the quality of care.

Most staff described an ethos of openness and transparency in responding to incidents but few staff were aware of the additional requirements of the Duty of Candour in handling incidents. Trust premises and community locations were well maintained, although facilities for the head injury service in Cambourne were inappropriate for the type of people using the service there.

Equipment was available for patients in their own homes and was usually delivered promptly. However, staff told us some patients had raised concerns about not receiving their equipment due to problems with deliveries.

There were significant staffing shortages in many of the community services we visited. Insufficient staffing was a particular concern for the Wycombe, Amersham, and Aylesbury ACHTs. There was also a shortage of physiotherapists and occupational therapists across almost all services. Staff told us that as a result of this, there were waiting lists for some services and that other services were scaled back.

Patient records were not always managed in a way that kept patients safe. The trust used a number of different electronic patient record keeping systems to record information about patients. These were often not linked together which meant that some services could not access information about patients which was held by other services. For example, most staff working in the community could not access patient records which were held by the acute services in the same trust.

Requires improvement

Are services safe?

Facilities we visited were clean and hygienic. There were good standards of hand hygiene as demonstrated through observation and audit results. Data provided by the trust covering the period January 2014 to January 2015 showed the numbers of catheter and new urinary tract infections were low, with no more than three cases being reported in any month during that period.

Most of the staff we spoke with told us they were up to date with mandatory and statutory training, although they usually completed online training modules outside of their contracted hours due to staffing pressures. The trust said that staff received time in lieu for any time spent on statutory or mandatory training.

Staff across all services described anticipated risks and how these were dealt with. Safeguarding protocols were in place and staff were familiar with them. Staff were able to describe the types of major incidents in which they could potentially be involved and the system for responding to major incidents.

Detailed findings

Incidents reporting, learning and improvement

- The trust had systems in place to record and report safety incidents, near misses, and allegations of abuse. Staff told us they were aware of procedures for reporting incidents
- From January 2014 to January 2015, in relation to its community services, the trust reported 23 serious incidents, 15 of which were for grade three and four pressure ulcers and four of which were breaches of patient confidentiality. In the same time period, the trust reported 917 incidents in community services, 96% of which were classified as 'no harm' or 'low harm.'
- Incidents and near misses were not always reported. Almost all the staff we spoke with told us there were rarely any incidents to report and staff in some services told us there had not been any incidents in years.
- Many of the staff we spoke with were not sure of the trust's definition of a reportable incident. They told us they would report any concerns involving patient safety as an incident but were not always clear about the kinds of concern they should report. Incidents staff said they would report included pressure ulcers, medication errors, lack of appropriate equipment and safeguarding concerns. We observed instances in which two separate patients experienced a fall. Staff promptly assisted these patients but, when we asked whether the incidents would be reported, staff told us such incidents were not routinely recorded or reported.
- There was a lack of clarity about who would report an incident which occurred during a home visit or in a community based clinic. At two of the focus groups we held, staff said there were safety concerns and issues they would report to their manager but would not report as an incident. Some of the staff we spoke with told us they would report an incident themselves. Others told us they would report an incident to their manager or to their care coordinator who would then record and report the incident. When we spoke with managers and case coordinators, they told us staff were responsible for reporting incidents that they witnessed or in which they were involved. This meant that there was a risk that accidents were not being reported and therefore the trust did not have an accurate picture of the number or type of incidents occurring in order to inform required changes.
- When we asked staff, they told us they did not always report delays due to lack of capacity in community teams, premature discharges or staffing shortages as incidents. Failure to report these as incidents puts the trust at risk of not being able to adequately assess the impact of these issues on service provision and the quality of care. For example, adult community healthcare teams told us that when patients were inappropriately discharged from hospital and referred to them, this affected their ability to prioritise their work and to provide appropriate care to patients.
- Staff told us there were opportunities to learn from incidents which occurred in their respective locality teams. For instance, a trust-wide policy on providing resuscitation was revised to include specific processes to be followed by staff working in community settings as opposed to an acute hospital environment. At the falls service we visited, staff gave examples of lessons which resulted in checks of the stability of furniture, a review of protocols for patients getting out of raised chairs, and increasing the visibility of chair raisers by identifying them with yellow tape.
- Night staff told us learning from reported incidents was shared with them through emails and memos. They were able to describe changes which had been made as a result of incidents. For example, night staff told us about a patient referral which had been misplaced and,

as a result, was not received by the community healthcare team. Learning from this incident led to referrals to adult community healthcare teams being followed by a telephone call.

- Staff told us there were good systems in place for learning from avoidable grade three and four pressure ulcers. Reviews of grade three and four pressure ulcers involved staff meeting with the chief nurse. Staff who had attended such a meeting described them as a positive and supportive learning experience.
- Managers told us incidents were discussed at locality management meetings and at team meetings. There was evidence of this in minutes of meetings we reviewed.
- Most staff said information about incidents was shared at team meetings and lessons learned were identified. We found, however, that incidents and learning from incidents were not always shared with staff. This was particularly the case with an incident which resulted in healthcare assistants not being allowed to administer insulin. The trust identified that the incident was discussed with healthcare assistants. However, the healthcare assistants we spoke with were unaware of the circumstances that led to the change in their duties and said they were not given an explanation as to the reasons.
- Staff in some of the services we visited told us they reported incidents but did not receive feedback about the outcome. Almost all staff we spoke with told us there was no system in place to ensure learning from incidents which occurred in other parts of the trust.
- In order to cascade learning from incidents the trust had introduced a 'lessons learned' session, a drop-in event open to everyone that was held on a monthly basis. These were promoted through emails and posters. A member of staff would present the incident. These took place at one of three sites in Aylesbury, Wycombe and Amersham. The event was held twice on the day and teleconferenced to enable attendance from a wider field. These had been in place for five months.
- In some of the areas we visited, we observed signs advertising 'lessons learnt' information sharing sessions. Some staff were aware of these but the majority of staff we spoke with were not. The staff who had attended these sessions said they found them helpful and were positive about them. They said, however, that access was limited as the sessions were only accessible by video conference from three locations.
- The majority of staff we spoke with told us they were supported and encouraged to report incidents. However, some staff expressed concerns about reporting incidents and felt that doing so might suggest a poorly performing service. They told us they were worried that an increase in reported incidents might be perceived as cause for concern rather than as an opportunity to learn and improve services. A minority of staff said they did not always have time to report incidents.
- The trust monitored safety thermometer data in relation to care provided to patients at home. Data provided by the trust covering the period January 2014 to January 2015 indicated the number of new pressure ulcers fluctuated throughout the year. Falls with harm saw an increase in October 2014, although the number of reported incidents fell after this.

Duty of Candour

- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred
- Staff across all the services we visited were unfamiliar with the requirements of the Duty of Candour legislation. Staff were aware of the importance of investigating incidents and potential mistakes but were not aware that the Duty of Candour now made investigating such incidents a legal requirement.
- Staff told us they had not had specific training in the Duty of Candour but some recalled having received some information about the new requirements either through an email or staff newsletter.

Safeguarding

- The trust had a safeguarding leadership team. The chief nurse was the board lead for safeguarding and was supported by a lead at associate director level. There was a lead professional for child protection, a lead nurse for child protection in the emergency department, a lead for safeguarding adults and a named midwife for child protection. The children's safeguarding team was further supported by five named nurses for child

protection, with four of these based in the community setting. The lead for safeguarding adults was supported by a safeguarding nurse based in the emergency department and a learning disabilities nurse. A plan was being implemented to introduce safeguarding champions at division level. These staff members would have a training role and work to ensure that staff were kept informed about guidelines and policies.

- Some locality teams had local safeguarding leads who they could access for support and who provided training in safeguarding, although not all staff we spoke with were aware of this.
- Staff told us they had training in adult and child safeguarding. Staff in almost all the services we visited were aware of safeguarding procedures and could tell us how they would raise a safeguarding concern. They were able to explain the types of concerns which would result in a safeguarding alert being raised and included concerns relating to children. There was, however, variable understanding of safeguarding and safeguarding procedures at Drake Day Hospital.
- Information provided by the trust showed low rates of completion of adult and child safeguarding training in some adult community healthcare teams (ACHTs). The data showed 91% of staff at Wycombe ACHT had completed adult and child safeguarding training. Safeguarding training at Aylesbury ACHT was completed by 55% of staff and by 62.5% of staff on the night ACHT.
- Staff said they felt confident in raising safeguarding concerns and were supported to do so by their managers. Staff we spoke with were able to give examples of safeguarding incidents they had been involved in and how these were escalated. They knew who to contact in order to report a safeguarding concern.
- Staff told us safeguarding concerns were reported as incidents, and we saw documentary evidence of this.

Medicines management

- Medicines were stored securely, stock was rotated to ensure medicines were used before their expiry dates, and refrigerators used to store medicines were checked daily to ensure they maintained safe storage temperatures. Medicines we saw were within their expiry date in all cases except at the Drake Day Hospital where we found some expired medicines. Staff disposed of these when we raised the issue with them.
- New staff completed electronic, computer based training in medicines management and their competency to administer medicines was assessed by a senior nurse (band 7). We saw thorough nurse competency frameworks for administering controlled drugs with syringe drivers.
- Nurses told us there was a nurse prescribing formulary, which had been developed with the trust's pharmacy team, and that this allowed them to prescribe medicines in a safe, consistent way.
- There were appropriate arrangements in place for the management of controlled drugs and medicines in patients' homes including individual stock checks and records of controlled drugs. We saw evidence of this in the patient records we reviewed.
- Staff who were not qualified to prescribe or administer medicines (for example, healthcare assistants and rehabilitation assistants) told us on home visits they sometimes prompted patients to take their medicines but did not give medicines to patients. The trust was developing competency assessments for non-registered staff to administer some medicines.
- Many of the staff we spoke with raised concerns about the trust's medicines management policy. They said it was a policy that was best suited to an acute hospital setting but not to most community healthcare working. One example they cited included the policy's requirement for controlled drugs to be administered by two nurses. They felt that while this requirement was appropriate in a hospital environment, it was not practical for community staff who often worked alone when providing care for patients, for example, during home visits, because they could not comply with the policy.

Safety of equipment and facilities

- With two exceptions, patients were treated in appropriately maintained environments. Where community facilities were rented in order to provide rehabilitation or balance courses, staff told us they were able to raise concerns about maintenance issues with the owner of the venue.
- The head injury service was provided from a location which was shared with other services. We found the facilities were inadequate to meet the needs of the patients using them. The premises were in urgent need of refurbishment and redecoration. There was limited space to consult and work with patients. Consultation

rooms and the rehabilitation kitchen were accessible through a series of long, narrow corridors. Staff told us many of the patients with whom they worked found navigating complex spaces difficult and were easily confused by the long corridors. There was no natural light in some of the rooms. Staff told us the lack of light caused many of their patients to develop headaches, a common effect of some head injuries, and that they tried to avoid using rooms without natural light when they could.

- The kitchen used to provide rehabilitation to patients using the head injury service was dim and cramped. Staff told us the kitchen was used for patient rehabilitation, for consultations with patients, for staff meetings, and as a staff eating area. We also found equipment and chairs were stored there. Staff reported that the phone lines were often out of order. This meant that anxious patients were not always able to get in touch with someone when they needed urgent support, they could not communicate their whereabouts or access assistance when lone working, and they were unable to carry out their day to day work effectively. Staff were aware the accommodation was not ideal but said that when they had raised concerns, these had not been addressed. Concerns with the facilities were not identified on the service's risk register.
- We found that some emergency resuscitation equipment was not checked daily although this had improved in March 2015. This was a particular issue in the multidisciplinary day assessment service (MuDAS). This posed a risk that required equipment might not be available in an emergency.
- Some physiotherapists raised concerns with us about the accessibility of wheelchairs. They told us there was a long waiting list for wheelchairs from the wheelchair service and so patients who needed wheelchairs did not always have them. They also raised concerns about the weight of wheelchairs being given to patients. They said the wheelchairs were too heavy for many patients and, when this was the case, patients were finding them too difficult to use.
- A central register of equipment was held by the trust. An audit had been undertaken over the previous 18 months to ensure that the register was up to date. There was an established planned preventative maintenance programme for all medical equipment. The system could track equipment that could not be found when maintenance or a service was due.
- The trust had taken a risk-based approach to the testing of portable electrical appliances. This was reported to be in line with guidance and meant that some items would be tested yearly and other items up to four yearly.
- Much of the equipment provided to patients for their own use was sourced from an external provider who was responsible for cleaning, servicing and delivering equipment to patients at home. Staff told us they were able to order equipment for patients when required and there was an electronic system for doing this. They also said that when they ordered equipment for urgent delivery, such as a pressure relieving mattress, the equipment was usually delivered within four hours. This was the case even on weekends and staff were able to give specific examples of this.
- However, some staff told us that although urgent equipment was usually delivered quickly, there had been problems with the delivery of non-urgent equipment. They said patients were given a target date for the delivery of the equipment ordered for them but the provider of the equipment often changed the date or time of delivery without notifying the patient. Staff told us there were also complaints from patients that delivery drivers were leaving before they were able to get to the front door to accept delivery of equipment. Staff told us the trust had raised these concerns with the provider of the equipment and the contract for the provision of equipment had been renegotiated as a result. However, staff reported that the issues continued to be raised by patients as complaints.
- Some staff also raised concerns about a five day waiting period from the time they ordered equipment to the time it was delivered to patients. They felt five days was too long for some patients to wait for required equipment and felt it put some patients at risk of harm. These staff said they had raised this issue with their managers but their concerns had not been not resolved.
- Equipment could also be loaned as needed from a trust-run storage service. The equipment loan service was run by a clinical specialist lead nurse who provided advice on selecting and using equipment. The lead nurse also collaborated with other staff groups including occupational therapists, specialist nurses, drivers and decontamination staff to ensure availability and provision of appropriate equipment for patients. Staff

felt the service from the trust run loan store was responsive and equipment was accessible. This equipment was also serviced and maintained by the external provider.

Records management

- Patient records were not always managed appropriately. The trust identified that all staff had access to electronic recording system and treatment plans should be documented in the notes. The staff in the MuDAS , however, told us they did not have access to the patient electronic record keeping systems provided by the trust. When we asked to see patient records for this service, we were told there were none. Some community services told us about another electronic system that was due to be rolled out.
- We found incomplete patient records in the neuro-rehabilitation service. Staff told us that some patient information was stored on the trust's electronic patient record system, and other information was kept in hard copy. We checked the electronic and hard copy records of five patients. The records of patients' progress notes were not present in any of the records we saw. We also saw one patient who was recorded on the electronic record keeping system as having been discharged from the service. Hard copy records for the same patient noted the patient was to be kept under review. We found no documented evidence of the patient's review. Staff told us notes of patients' reviews were sometimes kept separately from the main hard copy and the electronic records.
- The services and teams we visited used a combination of paper and electronic patient record keeping systems. Some paper records were held in patients' homes and we saw these during our home visits with staff. Almost all the patient records we reviewed included complete demographic information about patients, initial assessments, risk assessments, care plans and multidisciplinary reviews. Patient records included information about allergies, sensory or mobility impairments, medication, medical history and nutrition. Where appropriate, patient records also included the goals patients hoped to achieve. Progress against those goals was reviewed and recorded.
- Staff told us the trust had recently implemented a new system of mobile working which was intended to improve record management and allow for data about patient care and treatment to be recorded as it was provided to patients. Staff who had used the new system generally commented favourably on its usability and practicality but commented on occasional connectivity problems in rural areas, which delayed the input of patient information.

Cleanliness and infection control

- The community base and clinic environments we visited were clean and free from clutter. Hand hygiene gel was available in all the trust premises we visited and staff working in offsite clinics had portable bottles of hand gel, which we observed being used.
- We observed hand hygiene and infection control procedures were followed by staff during home visits with patients. Staff used personal protective equipment such as gloves, where appropriate. Staff told us they had no difficulties getting personal protective equipment when they needed it. We saw staff wiping down shared equipment after each home visit in which the equipment was used.
- Hand hygiene audits were carried out in community and clinic environments. Staff were able to describe these and told us results of these audits were fed back at team meetings. The audits we reviewed showed high levels of compliance with the trust's hand hygiene protocols.
- Staff told us they had infection control training which was provided through an electronic computer training package and face to face hand hygiene training sessions.
- Safety thermometer data provided by the trust covering the period January 2014 to January 2015 indicated the numbers of catheter and new urinary tract infections were low, with no more than three cases being reported in any month during that period.

Mandatory training

- Most of the staff we spoke with told us they were up to date with mandatory and statutory training, although they usually completed online training modules outside of their contracted hours. The trust said that staff received time in lieu for any time spent on statutory or mandatory training. Where face to face training with a trainer was required, staff told us they were not always able to attend because of staffing pressures.
- Minutes from trust's board meeting in November 2014 noted challenges in ensuring staff completed statutory training. There were no specific data relating to the

completion of statutory training within adult community services. However, minutes showed that 69% of staff in the integrated medicines division, which includes adult community services, had completed statutory training.

Assessing and responding to patient risk

- Referrals to other teams were made when required and we saw documentary evidence of this in the patient records we reviewed. Staff knew how to access advice from colleagues and told us they could raise concerns about patients' wellbeing with their manager to ensure they were addressed.
- In many of the services we visited, for example in neuro-rehabilitation and the head injuries service, patient referrals were assessed by a multidisciplinary team as part of a dedicated process for reviewing referrals. In community nursing teams, a clinical case coordinator reviewed new patient referrals and prioritised visits according to patients' needs and agreed care packages.
- Patients were given an individualised, multidisciplinary risk assessment regardless of the service they used. For example, patients had assessments as required for mobility, nutrition, pressure ulcers, mental and emotional wellness, occupational therapy and home environment. We saw evidence of this in almost all the patient records we looked at. Patients we spoke with told us of actions that had been taken as a result of risk assessment, for example, equipment they received at home, further advice or treatment, or referral to another service.
- Patients told us the needs of carers were also assessed and some could provide examples of care and support given to their carer as a result of such assessments.
- Incidences of pressure ulcers were monitored and investigated. Where there was an increase of pressure ulcers, the causes of this were reviewed and actions were put in place to prevent further occurrences. For example, staff told us there had been an increase in pressure ulcers in the Aylesbury Community Team. In response, the trust's tissue viability nurse provided additional training to the team and the team was reorganised so that expertise in preventing and managing pressure ulcers could be shared. Staff told us a new skin care bundle, which included documentation to support staff in assessing and treating patients at risk of developing pressure ulcers, would be rolled out to community nurses later this year.
- A trust analysis identified an increase in the number of pressure ulcers developing on patients' heels. Staff told us, in response, that the trust started to trial 'heel boots' to prevent these pressure ulcers developing.
- Staff we spoke with said they had training in cardiopulmonary resuscitation (CPR) and were aware of procedures for getting assistance in an emergency.
- There was resuscitation kit and/or a defibrillator at each of the locations we visited, although defibrillators were not always checked to ensure they remained in working order. Staff knew how to use emergency equipment.
- Patients who received care in their homes were given home risk assessments to identify risks to their safety and wellbeing, and to put measures in place to minimise these. We saw examples of these in patient records.
- Staff told us they used an adapted version of the National Early Warning Score (NEWS), which is most commonly used in acute hospitals, to identify deteriorating patients receiving intravenous medication. Staff said they had modified the tool to make it relevant for use in community settings.

Staffing levels and caseload

- Staff at all grades and in almost all the community services we visited told us that although they felt they were providing safe care, staffing levels were too low. Insufficient staffing was a particular concern for the Wycombe, Amersham and Aylesbury ACHTs. There was also a shortage of physiotherapists and occupational therapists across almost all services. Staff told us there had been difficulties recruiting a diabetic lead for the diabetic team.
- The trust did not use a recognised tool to calculate required staffing levels for its community services. However, managers recognised more work needed to be done to ensure appropriate staffing levels across all community services. Staff and managers told us staffing was being reviewed so that challenges around caseload and geography could be addressed.
- Data provided by the trust showed there was a vacancy rate of 36.9 and 20.1 whole time equivalents (WTE) in ACHTs and long-term conditions teams, respectively. Risks related to short staffing were identified on the trust's risk register. The trust's quality committee meeting minutes from February 2015 noted a 10% vacancy rate among therapies staff.

Requires improvement

Are services safe?

- Staff raised concerns about the impact staffing shortage had on patients and themselves. Staff told us they consistently worked beyond their contracted hours. Many community nurses told us they regularly worked more than 10 additional hours a week in order to make sure patients received the care they needed and patient records were up to date. This reflects findings from the NHS staff survey in 2014, in which the percentage of staff reporting they worked extra hours was higher than the national average. Community staff said they worked longer shifts or additional shifts to make up for staff shortages due to sickness absence and vacancies.
- Nurses and healthcare assistants said they were asked to help out on hospital wards or in other areas of the trust when there was a shortage of staff. They told us this resulted in added pressure for the remaining community based staff. They felt taking community staff away from their patients also resulted in a lack of continuity of care for patients.
- Staff told us there were two night teams with two nurses on each team. They said night nurses usually worked in pairs when doing home visits but that frequently a nurse on the Thame night team was moved to work on a hospital ward. Staff were concerned about the risks posed by a nurse working alone at night and about ensuring adequate cover to meet patients' needs.
- Some of the staff we spoke with told us supervision was often cancelled because of workload pressure. Many staff said they did their online training in their own time because there was not sufficient time to do it during their contracted hours.
- Staff told us they were not always able to attend multi-agency group meetings for discussing, reviewing and organising patient care. They said this was because their teams were short staffed.
- Staff on community teams told us routine, non-urgent appointments were cancelled when staff numbers were very low. In some locality teams, reablement staff told us they were sometimes unable to provide required rehabilitation for patients because they did not have enough time to practice exercises with patients, or had to support the nursing team doing home visits. They felt this had an adverse impact on patients because patients were not progressing as well as expected.
- There were long waiting lists for some services, particularly in therapy and rehabilitation based services which required physiotherapy or occupational therapy. For example, neuro-rehabilitation staff told us they aimed to see urgent patients within one to two weeks of referral but this was not being achieved. They said there was a wait of up to four weeks for urgent patients to have an initial assessment. Non-urgent patients could wait up to five months for an assessment. Managers and staff within the neuro-rehabilitation service told us they were developing a strategy to respond to the waiting list and there was a dedicated day set aside in May 2015 for this.
- The pulmonary rehabilitation clinic we visited was short of physiotherapists and staff told us this had contributed to a delay in providing one of the service's scheduled rehabilitation programmes.
- Nursing staff also told us of occasions where patients were admitted to hospital because community teams did not have capacity to meet their needs. For example, one team told us of a GP referral they received which identified a patient who needed to be visited by two community nurses, twice a day. The team did not have sufficient staff and the patient was admitted to hospital.
- Staff expressed concerns that even if established staffing figures were met, there would still be a shortage of staff to meet demand. Managers in many of the services we visited were not sure how staffing levels had been set. Many told us established staffing levels were historical and had not been reviewed for some time. They told us staffing allocations did not take into account increases in referrals from GPs or the need to provide longer term care to patients in the community. Managers told us the trust had commissioned an external review of its staffing numbers and skill mix across community locality teams and, as a result, were aware of the staffing pressures faced by adult community healthcare teams. There was a plan to develop a dependency tool to better understand required staffing needs.
- We met staff who told us their posts were funded by 'winter pressures money'. This was funding for the trust to enable it to respond to additional demands for services during the winter. These staff told us the funding for their roles would soon end. They expressed anxiety about this because they were not sure whether they would continue to be employed. Managers and other members of their teams expressed concerns about the impact a reduction in staff would have on their ability to provide services for patients.
- Senior managers were aware of the risks posed by low staffing levels and their concerns mirrored those of their staff. Managers told us of their efforts to recruit and

retain staff but said recruitment was an ongoing challenge. This was mainly, they said, because potential staff were attracted to nearby trusts which offered London weighted salaries. Salaries offered by the Buckinghamshire Healthcare NHS Trust were not London weighted.

- We found the various community teams we visited had taken steps to mitigate risks from staffing shortages. Many teams operated a system of prioritising patients or scaled back the services they offered. The cardiology team had trained one ward cardiology nurse to do both acute and community work, and had plans to train additional nurses in order to develop further capacity.
- Nursing staff told us they could request agency and bank staff when they needed to.

Managing anticipated risks

- Senior managers told us they worked with commissioners to identify and address seasonal variations in demand. The trust had received funding to employ additional community staff to cope with increased demand for services during the winter.
- Community nursing teams told us there were protocols for ensuring patients continued to receive care and home visits during inclement weather. For example, staff had access to a four-wheel drive vehicle if it snowed in order to reach patients in rural areas who would otherwise be cut off.

Major incident awareness and training

- Staff we spoke with were aware of major incident procedures and could tell us the arrangements for dealing with a wide scale emergency, for example, a major incident on the motorway. Some staff told us they had participated in a major incident training event.
- Staff also told us that in the event of a major incident they would prioritise patients who were most at risk of harm and ensure these patients had home visits. They also said they would rearrange rotas and caseloads to ensure there were adequate staff to conduct home visits.

Good

Are services effective?

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We rated effectiveness as 'good'.

Community services provided care based on clinical guidelines and took into account guidance from the National Institute for Health and Care Excellence (NICE). Services were developed using evidence-based practice.

The trust used a number of different electronic patient record keeping systems to record information about patients. These were often not linked together which meant that some services could not access information about patients that was held by other services. For example, most staff working in the community could not access patient records that were held by the acute services in the same trust.

Patient outcomes were monitored by individual services and information about these outcomes was included in the trust's divisional clinical governance reports. However, the divisional clinical governance reports included data from both acute and community services. There were limited systems in place to monitor the performance of community services specifically. Where performance was monitored, this focused mainly on processes rather than outcomes.

Community healthcare teams told us they responded to all referrals, even when they were short staffed, and that no patients were left without the care they needed. Patients we spoke with confirmed this and told us visits by community staff were rarely, if ever, missed. Staff told us the majority of patients were appropriately referred to their respective services. However, they expressed frustration that a significant percentage of referrals were made inappropriately because referrers did not understand referral criteria. For example, patients who required long-term care were sometimes referred wrongly to the reablement team, who could only provide short-term care.

There was an induction programme for new staff, and training and competency assessments for all staff in various aspects of their work. Staff across all the services we visited described good access to professional and specialist training. However, training in and understanding of the Mental Capacity Act 2005 was variable.

Community teams included physiotherapists, occupational therapists, district nurses and rehabilitation assistants. Therapy-based services included physiotherapists, psychologists, occupational therapists, and speech and language therapists. There was well established multidisciplinary team working across almost all the community services we visited. Telemedicine initiatives were in development in cardiology and in neuro-rehabilitation.

We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment.

Detailed findings

Evidence based care and treatment

- The trust had a range of policies and clinical guidelines available for staff. These were held on the trust's intranet and staff told us these were easily accessible. The policies we saw were up to date and based on current best practice guidelines such as those from NICE. We saw evidence of care provided in accordance with NICE guidelines and this was recorded in patients' records.
- We spoke with specialist teams across the trust including falls prevention, diabetes, tissue viability, respiratory, continence, neuro-rehabilitation, cardiac and stroke teams. These teams used best practice guidance to inform the care and services offered. For example, the community stroke team was established to promote early discharge from hospital with support from therapists. Patients received support for approximately six weeks, if required, to help them at home with their rehabilitation.
- Staff adhered to the NICE guidance on the prevention of pressure ulcers. Patient records we looked at showed risk assessments and care plans for patients who were at risk of developing pressure ulcers. During home visits, we observed nurses undertaking skin checks of bed-

bound patients and providing advice to patients about action they could take to avoid developing pressure ulcers. We saw patients were provided with pressure prevention equipment including cushions and pressure relieving mattresses.

- Evidence-based and professionally recognised tools were used to assess patients and monitor their response to treatment. For example, the Barthel Index of Daily Living to assess patients' physical readiness to return home, and the Berg Balance Scale to assess patients' balance and risk of falls.
- The trust employed lead and specialist nurses who supported education around best practice in their specialist areas, for example, in multiple sclerosis and Parkinson's disease. There were also specialist diabetes and respiratory nurses.
- There was a nurse prescribing formulary and a wound dressing formulary, which were used to support evidence-based and clinically effective care and treatment.

Use of Technology and telemedicine

- Telemedicine initiatives were in development in cardiology and in neuro-rehabilitation. This was in line with the trust's five year strategy.
- The neuro-rehabilitation service was due to implement a pilot telehealth project in April 2015. Staff told us the initiative was intended to improve the quality of patient care, particularly for patients suffering from fatigue and who found it difficult to attend appointments.
- Staff from the chronic fatigue management and chronic pain management services told us they had secured funding from the local council to offer a limited telehealth service. The service included the employment of an assistant psychologist three days a week to provide support to patients who were receiving therapy through an online computer programme offered by the trust.
- Staff told us telehealth services were offered by the chronic obstructive pulmonary disease (COPD) team. They said the service was intended to help patients to manage their own care but with the support of a clinician by telephone.
- Staff from the Thame ACHT told us the trust had, in the past, tried to introduce telehealth services in the locality but that full roll out had been indefinitely postponed due to staff shortages. Staff expressed frustration at not being able to progress telehealth services further but told us they recognised the need for further resources in order to do so. They told us two patients were receiving telehealth services from the Thame ACHT.

Activities to monitor quality and people's outcomes

- Patient outcomes were monitored by individual services and information about these outcomes was included in the trust's divisional clinical governance reports. However, these reports included data from both acute and community services. There were limited systems in place to monitor the performance of community services specifically. Most of the planned clinical audits of community services were either in the implementation or design stage.
- Data from the trust's quality dashboard from February 2015 showed quality measures specific to community services included the number of patient falls and grade three and four pressure ulcers. Almost all other performance indicators in the dashboard were related to process rather than patient outcomes, for example, the number of referrals made to specific services or the number of contacts made by adult community healthcare teams.
- Most of the services we visited measured patient outcomes as progress against individualised goals, which patients set for themselves with support from trust staff. This was done by assessing patients before and after treatment or rehabilitation, and measuring how much progress patients made between the two assessments. For example, reablement teams told us they used a tool called Measuring Outcomes in Services and Supports (MOSS) to set goals with patients and monitor their progress against them. We observed initial assessments for the purpose of goal setting being undertaken at the cardiopulmonary rehabilitation clinic we visited.
- Patients told us about the assessment process and how this was used to inform discussions about their individual goals and progress in achieving them. During one of our home visits, we observed a physiotherapist explain the suggested treatment and provide a detailed response to questions from the patient. The physiotherapist undertook an assessment of the patient's balance, and consent was obtained for the assessment. The physiotherapist and patient discussed possible goals. These goals were specific to the patient and clearly related to goals the patient wanted to

achieve. The physiotherapist explored short-term solutions with the patient, which aimed to encourage and promote the patient's independence. Changes in the patient's performance since the physiotherapist's last visit were also discussed along with any potential barriers to the patient achieving their goals.

- The community stroke and respiratory teams used other outcome measures, in addition to the progress measures, to monitor patient outcomes. Staff told us there was a quarterly audit of demographic information, time scales from referral to discharge, length of intervention, sessions the patient had with individual services, and use of profession-specific assessment tools. The results of the audit was used and reviewed within the team.
- Where applicable, community teams were involved in national audits. The stroke team contributed to the Sentinel Stroke National Audit Programme (SSNAP). There is no national figure given for these audits. Each domain is given a performance level (level A best to E worst) and a key indicator score is calculated based on the average of the 10 domain levels for both patient-centred and team centred domains. For October to December 2014 the trust attained a SSNAP level overall score of B for both patient centred and team centred.
- Adult community services participated in the National Intermediate Care Audit (NAIC) 2013–14. According to information sent to us by the trust, the trust achieved high scores against indicators for home care but the overall scores remained slightly below the national average. However, the trust was not an outlier. Staff were able to describe changes they had made as a result of the audit's findings. For example, the team checked a sample of patients each month to ascertain patient satisfaction with the care provided.
- Staff told us a detailed audit had been undertaken to identify whether improvements could be made to the trust's cardiac services. The audit found services could be improved by identifying inpatients on the trust's acute cardiac wards who would benefit from community support when they were discharged, and arranging support for them from community services. Staff us told the outcomes of this initiative were monitored and showed patient readmissions had been reduced since its implementation.

Competent staff

- There was an induction programme for new staff, and those we spoke with described their induction as a positive experience. They told us the trust induction included a six day mandatory training programme as well as additional training such as basic life support and medicines management. There was a concern that induction had been developed around the needs of staff working in acute services. Staff felt the induction programme needed to better incorporate training specific to community staff.
- Managers told us newly qualified staff worked with a preceptor and the trust's practice development nurse to achieve competencies in specific areas of work, for example, medicines management. Specialist, role-specific training was planned and booked before new staff started in post.
- Staff across all the services we visited described good access to professional and specialist training. Nurses were trained in assessing and treating leg ulcers, and their competency was assessed to ensure they provided appropriate care and treatment. Nurses and healthcare assistants told us they had training in dementia care.
- Individual members of the long-term conditions team were supported to complete modules at diploma or graduate level in long-term conditions.
- Staff in Thame ACHT told us they had training in wound care, osteoporosis, medicines management, dementia awareness and manual handling. Therapists told us they had a monthly training meeting which included therapists from different disciplines.
- Nurses told us they had good training and competency checks for administering medicines intravenously. Nurses told us they had training in the use of syringe drivers and described having a 'dummy' for training purposes. New syringe drivers were due to be rolled out across the trust. Several of the nurses we spoke with were trained to support and teach other staff to use the new syringe drivers.
- There were examples of staff working collaboratively to share learning and expertise. Staff in the neuro-rehabilitation service described an interdisciplinary training module they completed irrespective of the discipline in which they worked. They said they benefited from working in a highly skilled team and were provided with opportunities to learn from each other. Staff told us they attended multidisciplinary team meetings and these allowed them to share experiences and learning.

Good

Are services effective?

- Nurses praised the competency, experience, and skill of healthcare assistants. Managers told us a competency framework for healthcare assistants was in development and would include assessments for administering eye drops, providing simple dressings and giving insulin. One of the healthcare assistants we spoke with had completed additional training to provide continence assessments for patients and to train their team.
- Staff were concerned that much of the training they received assumed they worked in an acute hospital environment. One example was training in CPR. Staff told us the training did not address how staff should respond on home visits or while running a clinic off trust property. Community staff felt training needed to be tailored to their needs. Specialist nurses told us they sometimes had to cancel training they were scheduled to provide because managers could not release staff to attend training. Staff and managers told us there was a need to introduce preceptorship training.
- Most of the staff we spoke with told us they had annual appraisals but that supervision was difficult to arrange because of staffing pressures. Most nursing staff we spoke with told us they did not have clinical supervision although staff on some teams told us they had group supervision. Therapists told us they had regular clinical supervision.

Multi-disciplinary working and coordination of care pathways

- There was well established multidisciplinary team working across almost all the community services we visited. The one exception was at the Drake Day Hospital where staff told us staffing pressures made it difficult to hold multidisciplinary team meetings to review patients other than those with Parkinson's disease.
- Community teams included physiotherapists, occupational therapists, district nurses, and rehabilitation assistants. Therapy-based services included physiotherapists, psychologists, occupational therapists, and speech and language therapists.
- Community and acute services worked together to identify patients who did not require treatment in hospital and who would benefit from care in the community. For example, the community transfer care team identified inpatients who were ready for discharge and arranged community care for these patients. There was also a rapid emergency assessment care team (REACT) based at Stoke Mandeville's accident and emergency (A&E) department. The team was made up of a physiotherapist, occupational therapist, social workers, nurses, a pharmacist, a consultant, and a GP. Its remit was to coordinate community care for patients in A&E who did not need to be admitted to hospital. Community staff told us these services worked well.
- Community cardiology and respiratory services were integrated, with acute and community staff working together as one team. Staff in both these services felt the integration allowed for improved coordinating between acute and community services and, therefore, better management of patients' care and treatment.
- Staff felt well supported by specialist nurses, and told us they could contact colleagues from other disciplines if they needed help or advice in a specific area.
- Staff described close working with local GPs. District nurses attended multidisciplinary agency group meetings led by and held at GP practices. Nurses told us attendance at these meetings was a good opportunity to share and receive information about patients, particularly those with complex care needs. They said the meetings were used to prevent unnecessary admissions to hospital.

Referral, transfer, discharge and transition

- Staff told us there were occasional instances of inappropriate discharge from acute services. The challenge, they felt, was in ensuring patients were discharged to the appropriate community team with completed discharge summaries and clear information about medication.
- Managers told us of plans to develop a single point of access for all seven adult community healthcare teams from which referrals would be reviewed and forwarded to appropriate services. They felt this would streamline the referral process and would result in patients receiving the care they needed more quickly. However, these plans were in early development at the time of our visit.
- Staff on different teams told us the majority of patients were appropriately referred to their respective services. However, they expressed frustration that a significant percentage of referrals were made inappropriately because referrers did not understand referral criteria. Referrers included staff from the trust's acute services. For example, patients who required long-term care were sometimes referred wrongly to the reablement team who could only provide short-term care.

Good

Are services effective?

- We were told referrals often did not include adequate information about patients' medicines. This meant nurses spent considerable time, up to an hour and half for each patient, calling GPs and doctors in order to clarify which medications and in what dosages patients were to be given medicines. Staff felt more work needed to be done to ensure referrers understood what information they needed to send as part of a referral and what services are actually offered by community teams. Staff told us the effect put additional strain on their services and delayed care for patients.
- Staff also raised concerns that acute services were providing erroneous information to patients about services that were available in the community. For example, patients were sometimes told they would receive support for six weeks when the community team could only offer two weeks' of support. Community staff felt work was needed to raise awareness of the services they offered so that patients were given correct information about the services they could expect to receive.
- We looked at referral records for the physiotherapy service offered at the Drake Day Hospital. We found patient referrals were reviewed to determine whether patients required physiotherapy or would benefit from referral to another service. The records we looked at showed that between 9 September 2014 and 26 March 2015, there were approximately 125 referrals recorded as having been received by the physiotherapy team. About 80% of these referrals were deemed to have been made incorrectly and were forwarded to another team, mainly the falls service. Patient care was delayed as a result.
- Reablement teams formed part of the adult community healthcare teams in all seven community localities. Staff told us reablement teams provided short-term care to help patients transition from a hospital environment to living at home. Reablement staff told us their services were sometimes used to ensure patients were supported at home while a care package was agreed with social services.

Availability of Information

- The trust used a number of different electronic patient record keeping systems to record information about patients. These were often not linked together, which meant that some services could not access information about patients which was held by other services. For example, most staff working in the community could not access patient records which were held by the acute services in the same trust.
- The exception to this included the integrated respiratory service, which could access electronic records kept in the trust's A&E department. An entirely separate electronic system was used to record patient information in the heart failure and cardiac rehabilitation service.
- Staff we spoke with recognised the risks of using multiple patient record keeping systems, including loss of patient records, miscommunication, and inadequate or unsafe patient care. Staff explained how they tried to mitigate these risks. For example, the specialist cardiac nurse would request that a porter delivered clinic notes to another clinician if they were aware a patient from the clinic was about to receive treatment elsewhere in the trust.
- However, staff expressed frustration at the additional strain they felt this put on them. They said much of their time was spent trying to obtain accurate information about patients from other services within the trust. They felt this was time they could not spend providing care to patients.

Consent

- We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment.
- Training in and understanding of the Mental Capacity Act 2005 was variable. Some staff told us they had completed training in the Mental Capacity Act but their understanding of how this legislation affected their work was limited. Most of the staff we spoke with, however, had not had training in the Mental Capacity Act.
- Staff had received mandatory training in safeguarding.

Good

Are services caring?

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

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

We rated 'caring' as 'good'.

We found staff were caring and compassionate. Without exception, patients we spoke with praised staff for their empathy, kindness and caring. Some patients described what they felt were examples of staff going above and beyond the requirements of their job in order to ensure their wellbeing.

With one exception, we observed patients being treated with dignity and respect throughout our inspection. We observed staff conducting clinical observations of patients in the multidisciplinary day assessment service (MuDAS) and weighing them in a publicly accessible area in front of other staff, patients and visitors. Staff we spoke with told us the service did not have treatment rooms and so there was no dedicated space to speak with patients privately.

During home visits, staff were polite and professional. They explained the care and treatment they had come to provide and checked patients understood what would happen during the home visit. Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns. We found staff had a good rapport with patients and patients were comfortable with the staff who visited them.

Where patients received rehabilitation, both at home and at clinics, they were encouraged to work at their own pace. Where patients identified barriers to achieving their goals, staff explored possible solutions to these barriers with them. Patients were supported to maintain their independence.

Detailed findings

Dignity and respect, and compassionate care

- Throughout our inspection we witnessed patients being treated with dignity and respect. Where initial assessments and reviews were held at day centres, this was done quietly and in a private area. Initial assessments held in rehabilitation clinics, where facilities for maintaining confidentiality were sometimes limited, were undertaken quietly and away from other patients.
- During home visits, staff were polite and professional. They explained the care and treatment they had come to provide and checked patients understood what would happen during the home visit.
- On one home visit, a patient told us they were given the opportunity to choose the day on which to be visited by a nurse as opposed to having been given a date. They also said they had asked to be contacted by phone prior to the actual appointment so they could have a bath. The patient told us the nurse had phoned, as requested, an hour before the appointment.
- We observed one instance where patients were not treated with dignity and respect, and where patient confidentiality was not maintained. We observed staff conducting clinical observations of patients and weighing them in a publicly accessible area in front of other staff, patients and visitors. Staff we spoke with told us the service did not have treatment rooms and so there was no dedicated space to speak with patients privately. They said they had raised this as a concern with their managers but the issue had not been addressed.
- We spoke with patients and carers covering all the community services we visited. We spoke to patients in clinics, at rehabilitation classes, by visiting them at home, and on the telephone. With few exceptions, patients and carers praised the professionalism of trust staff. They said staff were caring and supportive.
- Patients from the neuro-rehabilitation service and the head injuries service spoke very highly of the staff who supported them. They felt staff went above and beyond what could be expected in order to help them cope with their conditions and that this had a profound, positive effect on their quality of life. For example, patients said staff helped them get bus passes and apps for their phones (to help them remember to do various tasks). One patient told us staff had liaised directly with their builders in order to help resolve a dispute.

Good

Are services caring?

- On one of these visits, the patient raised concerns about their carer's health and wellbeing. The nurse then approached the carer offering support and advice. After a discussion and assessment of the carer's needs, the nurse referred the carer for further support.

Patient understanding and involvement

- Patients and carers we spoke with felt involved in their care. They told us they were encouraged to set goals as part of their treatment plans and felt the goals they set were specific to their needs and circumstances.
- Patients told us staff reviewed their goals with them and provided encouragement if they were unable to meet their goals.
- Patients said they were given sufficient verbal and written information about their care and treatment. They told us that when they had questions, staff answered and provided clear explanations. Patients told us they had access to their care plans and, on home visits, we saw copies of these in patients' homes.
- During home visits, we observed patients being involved in discussions about their care and treatment. Patients and carers were included in discussions about patients' progress and encouraged to ask questions. For example, we observed a physiotherapist explain the suggested treatment and provide a detailed response to questions from the patient. The physiotherapist and patient discussed possible treatment goals. These goals were specific to the patient and clearly related to goals the patient wanted to achieve. The physiotherapist explored short-term solutions with the patient which aimed to encourage and promote the patient's independence. Changes in progress since the physiotherapist's last visit were also discussed along with any potential barriers.

Emotional support

- Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns.
- When we accompanied staff on home visits, we found they treated patients compassionately and sensitively. We observed staff ask patients how they had progressed since their last visit, and whether they had any concerns or required further support. We found staff had a good rapport with patients, and patients seemed comfortable with the staff who visited them.
- Where patients received rehabilitation, both at home and at clinics, they were supported to work at their own pace. Where patients identified barriers to achieving their goals, staff explored possible solutions to these barriers with them.
- Staff in the neuro-rehabilitation service told us they were trained to provide emotional support to patients. There was a psychologist on the team who offered psychological and emotional support to patients and their families. The neuro-rehabilitation service was an open access service. Staff told us this meant patients and their families could call or walk in without an appointment if they needed support or if a patient was in crisis.

Promotion of self-care

- Patients told us that help from staff had enabled them to manage their conditions.
- Telehealth programmes were used in some of the trust's community services and staff told us programmes were intended, in part, to promote self-care. They felt telehealth services were successful in achieving this aim.
- Reablement teams provided short-term support to enable patients regain their independence after discharge from hospital. Staff from these teams told us they often helped patients get equipment they needed, and assisted them in eating and in performing personal care activities.
- We observed patients who were diagnosed with diabetes being encouraged and supported to manage their condition in an educational programme called 'Life and health with diabetes'. Staff told us the programme was intended to improve understanding of diabetes to empower patients to manage the condition.
- Where patients needed equipment in order to maintain their independence, this was provided, although there were some concerns about the prompt delivery of non-urgent equipment. Patients told us they received required equipment when they needed it and were shown how to use it. Staff told us the provision of equipment helped patients maintain their mobility, dignity and self-reliance.
- Staff on the respiratory team told us they regularly referred patients to pulmonary rehabilitation classes, in part, to promote self-care.

Requires improvement

Are services responsive to people's needs?

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

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

We rated 'responsive' as 'requires improvement'.

Services were planned to meet the needs of different people but the delivery of the service was sometimes constrained by staff shortages. This meant there were long waiting lists for some services and sometimes only the most urgent patients could be treated. There were waiting lists for services provided at day hospitals, for some rehabilitation courses, and in therapy-based services. Some of the patients who had used the chronic pain and chronic fatigue management services told us they had waiting a long time to get onto a group therapy course. One of these patients had waited seven months from the time they were referred to get onto the course.

A frequent concern raised with us by patients was having to wait long periods of time for transport to and from the services they needed. A small number of patients told us they missed appointments because of delayed transport. Patients with cognitive impairments, for example those receiving neuro-rehabilitation and patients with head injuries, told us the delay in transport sometimes caused them considerable anxiety and distress. There were ongoing discussions with the transport provider to improve services.

There were good examples of services being responsive to people's needs. The trust's diabetic team provided a three week education session over Ramadan for healthcare professionals and a drop-in programme for patients who had diabetes to help them make adjustments to their medication while fasting. Therapy for chronic fatigue and pain management was delivered in a variety of ways and education sessions were provided to patients to familiarise them with different treatment options. Patients from the head injury service were referred to a wood working group, which was provided by an occupational therapist and volunteer trainer. However, the head injuries unit in Cambourne provided limited access for people with wheelchairs.

Managers in many of the services we visited explained how they worked with commissioners to plan and deliver services to meet the needs of local populations. For example, managers in the integrated stroke, respiratory, and chronic pain and fatigue management services described how their specific services had been developed with commissioners.

Detailed findings

Planning and delivering services which meet people's needs

- Services were planned to meet people's needs but the delivery of services was sometimes constrained by staff shortages. For example, there were two community night teams providing night services across the county but staff told us often only one team was operational. The trust had used winter pressures funding to provide additional resources to maintain night services. The effect of the additional funding was being evaluated and continuation of the service was under discussion with commissioners.
- Night staff told us there were no formal links with local out-of-hours services to which patients could be directed so that they could be dealt with more promptly when community night services were stretched.
- Staff told us the lymphoedema clinic in the south of the county had recently closed due to lack of funding, and this left only one lymphoedema clinic, which was based in the north. This has resulted in approximately 100 patients not having access to a lymphoedema specialist. The trust identified to us that the clinic but staff were not aware of this.
- Managers in many of the services we visited explained how they worked with commissioners to plan and deliver services to meet the needs of local populations. For example, managers in the integrated stroke, respiratory, and chronic pain and fatigue management services described how their specific services had been developed with commissioners. Managers of these services told us they submitted an annual report of patient outcomes to commissioners.
- A frequent concern raised with us by patients was having to wait long periods of time for transport to and from the services they needed. A small number of patients told us they missed appointments because of delayed transport. Patients with cognitive impairments,

for example those receiving neuro-rehabilitation and patients with head injuries, told us the delay in transport sometimes caused them considerable anxiety and distress. There were ongoing discussions with transport provider to improve services.

Equality and diversity

- Staff told us interpreters were easily accessible. Specialist tuberculosis (TB) nurses told us they provided services to patients from a range of ethnic backgrounds and languages, and used interpreters regularly.
- Staff told us they had access to a trust-wide lead for learning disabilities.
- All of the services we visited, except the head injury unit in Cambourne, were accessible to people using mobility aids through the provision of ramps and lifts. Narrow doorways and corridors in the head injuries unit limited access for people with wheelchairs. Disabled parking was available at all the locations we visited.

Meeting needs of people in vulnerable circumstances

- Staff told us the multidisciplinary day service (MuDAS) at Wycombe Hospital was developed to meet the needs of older people. A community geriatrician provided medical assessments when patients were referred by their GPs. The same geriatrician also worked in the rapid emergency assessment care team (REACT) in A&E to help prevent unwanted admissions to hospital.
- The trust provided a community diabetic service, which offered two hour clinics twice a week for non-English speaking patients, and provided interpreters. Clinics could be accessed by appointment or drop in. There was also a three week education session provided over Ramadan for healthcare professionals and a drop-in programme for patients who had diabetes to help them make adjustments to their medication while fasting.
- Patients using the trust's head injury service were referred to a wood working group, which was provided by an occupational therapist and volunteer trainer at a community school. Staff told us the programme was intended to develop patient's confidence and teach them practical skills. We visited with the group for one session. We saw that activities and record keeping were designed around the specific needs of the patient group, which included learning to cope with memory loss. For example, staff took pictures of each patient's work at the end of every session so that when patients returned for their next session, they had a reminder of where they had stopped. Patients were very pleased with the service and felt it provided a supportive environment where they could learn new skills.
- The chronic pain and chronic fatigue management services offered therapy and support in a variety of ways. Staff told us patients could have one to one therapy, group therapy, and access to support offered through an online programme or a CD coupled with telephone support from staff. We were told information sessions were provided for patients so that they were aware of these treatment options and could choose whichever option they felt suited them best. Staff told us they had looked at alternative ways of providing therapy both to meet the demand for services and to cater for the needs of a patient group that sometimes found it difficult to attend face to face therapy.

Access to the right care at the right time

- Community nursing staff told us sometimes patients with complex care needs could not be discharged from hospital because there were insufficient community staff to provide the care they needed.
- The trust was monitoring waiting times but the information was not available for adult community as it was not separated or disaggregated into information that applied to adult community services. Consequently, the trust did not have data to demonstrate overall waiting times.
- Staff told us there was a 14–16 week wait for patients to access services at the Thame Day Hospital because there were insufficient staff to provide the service.
- The pulmonary rehabilitation clinic we visited was short of a physiotherapist, and staff told us this had contributed to a delay in providing one of the service's scheduled rehabilitation programmes.
- Staff at the Drake Day Hospital told us they prioritised the most complex patients, for example those patients requiring neuro-rehabilitation, and that other patients could not be treated because there were not enough occupational therapists. The night service for the south of the county was sometimes closed because there were no staff to provide services. This put pressure on Amersham staff to cover calls from anywhere in the county and patients sometimes had to wait for long periods of time to be seen.
- There were waiting lists for services provided at day hospitals, for some rehabilitation courses, and in

therapy-based services. Some of the patients who had used the chronic pain and chronic fatigue management services told us they had waited a long time to get onto a group therapy course. One of these patients had waited seven months from the time they were referred to get onto the course.

- Waiting times from referral to treatment varied between community services. Staff from community healthcare teams told us patients did not wait for treatment and that referrals were addressed promptly due the nature of their services. There were, however, delays in treating patients in other services. We looked at four sets of randomly chosen patient records in the neuro-rehabilitation service. The records showed that two of the patients had been referred to the service in February 2015 but had not had an initial assessment at the time of our visit.
- Where patients were waiting for treatment, urgent cases were prioritised. Staff described eligibility criteria and were able to explain the process for prioritising patients.
- Community healthcare teams told us they responded to all referrals, even when they were short staffed, and that no patients were left without the care they needed. Patients we spoke with confirmed this and told us visits by community staff were rarely, if ever, missed.
- A single point of access to reablement teams for both health and social care services was being developed by the trust. Staff told us there had previously been a reablement team offered by the trust and one offered by social services. They said the difference between the two teams was not well understood and had caused considerable confusion among patients. To alleviate the confusion, a single point of access for both teams had been agreed. Where patients were referred to reablement teams and were waiting for a placement, there were daily conference calls between services to ensure patients' needs were understood and that appropriate care packages were in place to meet their needs.
- Staff from the respiratory team told us there was a single point of access seven days a week for specialist nursing services provided by their team. Patients, GPs, community nurses and staff from the hospital's inpatient wards could ring the team on a dedicated phone number for advice and support. Staff told us the phone was staffed a rota basis.
- The trust's tissue viability service operated an open access policy and took questions from all callers including patients, staff and other services.

Complaints handling (for this service) and learning from feedback

- The trust had policies and procedures on complaints handling which was available on its intranet site. Staff told us there were clear arrangements for responding to complaints and they could escalate concerns to their managers.
- Information about how to make a complaint was available in some of the areas we visited but not in all. For example, there was no information in the MuDAS about how to make a complaint.
- Themes from complaints were analysed, although information provided from the trust showed there were few complaints received about the trust's community services. The main themes the trust identified from complaints it received about its community services between January and December 2014 were lack of family involvement in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) decisions, completeness of post-discharge care plans, access to a community inpatient facility, general nursing care, delays in receiving community services after a referral, and lack of supplies from the continence service.
- Staff were aware of complaints and how the trust was responding to these. They told us they rarely received complaints about community services but that the most common complaints related to transport and the delivery of equipment.
- Those staff who had been involved in complaints were able to tell us how they had dealt with them. They told us complaints were investigated and they were given feedback about complaints at team meetings. We saw minutes of team meetings and they reflected what staff told us.
- Staff were able to provide examples of changes they had made to services as a result of patient feedback. For example, staff in the neuro-rehabilitation service told us that as a result of complaints from patients, they had identified a need to raise awareness of the service among GPs in the area.

Requires improvement

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.

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.

We rated 'well-led' as 'requires improvement'.

Trust-wide governance and leadership arrangements did not have sufficient consideration and understanding of community services. Most staff we spoke with felt they could discuss concerns with their line manager but many felt the trust's senior management could do more to involve them in discussions that affected community services. Staff identified the availability of community services and referral criteria as being key areas for improvement, as well as training, and policies and procedures that needed to better reflect the context in which community staff worked.

There were a number of interim management arrangements in the adult community healthcare teams but staff were not always aware of what the interim arrangements were. For example, in one locality team, the staff we spoke with were not sure who their manager was. When members of the team explained how they would escalate concerns, they made repeated references to a manager who was no longer in post.

Performance indicators were used by management to monitor the quality of community services, but performance outcome data for community services only were limited. For example, the community services quality dashboard combined data from all seven community localities and it was not possible to review results by individual adult community healthcare team. Where outcome data were available for community services, they were usually aggregated with patient outcome data from the trust's acute services.

Managers were able to discuss the trust's vision and five year strategic plan, particularly those aspects relating to community services, and describe the challenges the trust faced in implementing them. Elements of the trust's strategic plan had been or were being implemented in relation to adult community services. Staff were focused on achieving key outcomes and these were linked to the trust's vision and strategy.

There was a clear emphasis on teamwork in all the services we visited. We found staff worked hard to maintain a high standard of care despite difficulties with staffing and capacity. Lessons from incidents and complaints were usually shared within the services in which they occurred, but lessons learned from other services within the trust were not routinely communicated.

Patient feedback was collected and used in planning many of the services we visited, most frequently through surveys or focus groups. Feedback from patient surveys shown to us by community services staff was, almost without exception, positive. Where patient feedback was not routinely collected, plans were in place to address this.

Performance outcomes were monitored and key risks were identified and escalated to the trust's risk register. Managers of community services recognised concerns about the sustainability of current staffing levels and described initiatives to address this. There was a clearly embedded ethos of improvement and innovation in some services. This was particularly the case in cardiac rehabilitation and respiratory services, as well as the chronic fatigue and pain management services, and the community diabetes service.

Service vision and strategy

- The trust had a vision and strategy for developing the organisation called 'Working together for excellent care in Buckinghamshire', and community services were included in this. Central to the strategy was the aim to integrate acute, community and primary care services in the area for the benefit of patients. Managers were able to discuss the strategy and describe the challenges the trust faced in implementing it. Staff we spoke with were aware of the strategy and described integration and high quality patient care as key components of the trust's vision.

Requires improvement

Are services well-led?

- We found many elements in the strategy that related to adult community services had been or were being implemented. This included the integration of the community falls and bone health service, the development of a single access point for referrals, ACHTs working closely with GPs, and closer working with social care reablement teams.
- There was also evidence of engagement with new technology, an important facet of the trust's strategy and vision. Arrangements for mobile working were available to many community staff, the number of services offered through telehealth were growing, and there were plans for one integrated patient electronic record keeping system across health, social and primary care services. There was a high level of staff awareness of these developments.
- Staff were focused on achieving key outcomes and these were linked to the trust's vision and strategy. These included reducing unnecessary patient admissions to hospital, shortening patients' length of stay in hospital, and working towards integrated services.

Governance, risk management and quality measurement

- Community services were part of the trust's integrated medicines division. Within this division, community services were divided into service delivery units. There were a number of service delivery units including integrated community and elderly care, diabetes and endocrinology, cardiology, respiratory, and neurology and stroke.
- Each service delivery unit had its own clinical governance meetings and reported to the division's board. Minutes of these meetings showed reviews of risk registers, performance data, audit activity and results, infection control, new clinical guidelines, complaints, incidents and staffing issues.
- Divisional board meetings were attended by representatives of the service delivery units within the division. Minutes from these meeting showed there were reviews of risks, incidents, audits, performance, and complaints relating to both community and acute services. Notes from divisional meetings recorded the sharing of information across service development units and across the trust.
- The divisional board reported to the trust's quality committee, which is a subcommittee of the trust's board. Included in these reports were analyses of audit findings, types of incidents, risks, and other quality metrics.
- Each of the community healthcare teams we visited told us they had monthly team meetings during which they discussed new policies and professional guidelines, incidents, concerns, complaints and risks. Staff also told us they had feedback from locality managers' meetings, which were attended by community managers. We saw minutes of team meetings and they reflected what staff told us.
- Most staff we spoke with felt they could discuss concerns with their line manager but many felt the trust's senior management could do more to involve them in discussions which affected community services. They cited understanding of available community services and referral criteria as being key areas for improvement. They also felt the content of training as well as policies and procedures sometimes needed to better reflect the context in which community staff worked.
- There was a quality dashboard which was used to monitor the performance of adult community healthcare teams against a number of indicators. However, the dashboard combined data from all seven community localities and it was not possible to review results by individual adult community healthcare teams.
- Divisional performance scorecards were reviewed by the division's board. The scorecards included information drawn from quality dashboards and included additional information relating to pressure ulcers, falls, venous thromboembolisms (VTEs), infection control, staffing and finance. However, patient outcome data for community services alone were limited. Where data was available, they were usually aggregated with patient outcome data from the trust's acute services.
- The trust was not monitoring access and waiting times to all services and had not identified some of the issues and delays raised , tothe inspection team, by patients and staff.
- There were risk registers for individual services, although some of the risk registers we saw did not always include risks we identified during our visit. For example, the risk register for the head injury service did not identify concerns about the suitability of the premises.

Requires improvement

Are services well-led?

- Lessons from incidents and complaints were usually shared within the services in which they were reported and were discussed at both service delivery unit and divisional level. However, lessons learned from other parts of the organisation were not routinely shared with front-line staff to ensure shared learning across the organisation.

Leadership of this service

- Each adult community healthcare team or service had a manager who provided day-to-day operational leadership to members of staff on their team. Staff told us their local managers were very supportive and would raise concerns on their behalf.
- There were mixed views from staff about the visibility of the senior leadership team for the trust. Many of the staff we spoke with knew the chief nurse by name and some teams told us they had been visited by the chief nurse. Those staff who had worked with the chief nurse described it as a positive and supportive experience.
- There were a number of interim management arrangements in the adult community healthcare teams and staff were not always aware of what these were. For example, in one locality team, the staff we spoke with were not sure who their manager was. When members of the team explained how they would escalate concerns, they made repeated references to a manager who was no longer in post.
- Some locality managers were covering management vacancies in other localities in addition to managing their own teams. This put pressure on some locality managers to juggle the leadership and management of multiple teams. Some of the locality managers had not had one to ones or supervision in the previous six months despite supporting multiple teams. They told us they contacted the lead nurse or associate chief nurse if they needed support.
- Managers of community services were encouraged to complete leadership training through the NHS Academy and we spoke to managers who were in the programme.
- There was an allied healthcare professional lead to represent these workers at trust board level. However, most of the therapists we spoke with did not know there was an allied healthcare professional lead.
- Staff told us there was good leadership of the chronic pain and chronic fatigue management services but were concerned that there was limited succession planning in regards to leadership. Staff felt there was a risk the service would not be able to continue in future if additional managers could not be identified to lead the service.
- Staff shared good practice within their individual teams but the sharing of good practice between services was limited. Staff shared with us many examples of good practice and innovative programmes that were developed within their respective teams but told us this was not routinely shared with other services.

Culture within this service

- Staff had mixed views about the culture of the trust. They described their local teams as being open and supportive but sometimes felt marginalised by the trust. They felt community services were not yet fully integrated into the organisation and that trust management struggled to understand the needs of community staff.
- Staff were frustrated that much of the training they received was based on the needs of staff working in a hospital environment and failed to recognise that community staff often worked outside of hospitals. They also felt many policies and procedures were aimed to support staff working in hospitals and had limited application in community settings. Two of the most frequently criticised policies were the medicines management and lone working policies.
- Staff generally felt well supported by their managers. Staff told us they worked well together and could rely on the support and goodwill of their colleagues.
- There was a clear emphasis on multidisciplinary team working and mutual respect between staff throughout all the services we visited. There was routine engagement with other services, both internal and external, to ensure patients' needs were assessed and met.
- There was a strong ethos of compassionate care and we observed examples of compassionate care from staff in all services. We found staff worked hard to maintain a high standard of care despite difficulties with staffing and capacity.

Staff Safety - Lone Working

- There was a trust-wide lone working policy, although staff across community services showed varying levels of familiarity with it. Some staff were able to give us examples of changes they had made as a result of the

lone working policy, for example, one community team had introduced documented risk assessments for home visits. Staff told us these were intended to protect staff but also allowed staff to identify potential barriers to patient care, for example, whether a patient needed care from more than one member of staff.

- Most of the staff we spoke with raised concerns about the trust's lone working policies. They said lone working policies tended to apply to staff working in the trust's acute services and did not always apply to community services. Staff told us this had resulted in informal lone working arrangements which varied by locality.
- Staff told us the lone working policies had been revised recently. However, staff said they were not consulted on the new policies and felt they were not given opportunities to suggest lone working arrangements which would better reflect the needs of community staff. Senior managers acknowledged staff were not involved in the review of the trust's current lone working policy and said they had used historical feedback from staff in its development.

Public engagement

- There were examples of patient feedback being collected and used in planning many of the services we visited. This was most often through surveys or focus groups. For example, the neuro-rehabilitation team held focus groups with patients to identify areas that worked well and those that required improvement. The chronic pain and chronic fatigue management services collected patient feedback using a survey and staff told us they had recently revised the survey template to get more feedback on specific issues.
- Feedback from patient surveys shown to us by trust staff was, almost without exception, positive. Patient comments about referral, communication, care, treatment, equipment, and an exercise programme at the Thame Day Hospital were positive.
- Where patient feedback was not routinely collected, this was being addressed. For example, staff on the community stroke team told us they had developed a patient feedback questionnaire with the Stroke Association carers group.

Staff engagement

- NHS staff survey results from 2014 showed the trust's performance was rated higher than or the same as the national average for staff receiving equality and diversity training, having an appraisal in the previous 12 months, and having a role that makes a difference to patients. Areas in which staff did not feel the trust performed well were raising concerns about unsafe practice, getting support from immediate managers, and communication with senior management. The trust scored in the lowest 20% of trusts taking part in the survey for staff engagement.
- Most staff could not recall having met other members of the trust's senior leadership. They felt this was indicative of the trust's response to its community services and expressed frustration at feeling unheard by senior management.
- Staff were involved in a consultation about a review of adult community healthcare teams, which was instigated in response to concerns about staffing levels. There were also plans to involve staff in new initiatives such as the implementation of a single point of access.
- Information was sent to staff regularly by newsletter and by email. Staff told us there was an intranet site and showed us the information they could access on the site. There was a regular blog from the trust's chief executive and many of the staff we spoke with had read the blogs.

Innovation, improvement and sustainability

- Managers recognised concerns about the sustainability of current staffing levels and told us there was an ongoing recruitment campaign to address this. They also described other initiatives which were intended to reduce pressures on staff while also improving services for patients, for example, the use of mobile technology, establishment of single access points for services, and further integration of services. There remained concerns among community management and staff, however, that these developments would not alleviate staffing pressures in some areas, for example, physiotherapy and occupational therapy.
- All the teams we visited demonstrated a commitment to providing patients with the best care they could. However, many of the staff we spoke with, particularly those on the community adult healthcare teams, told us that the day to day demands of their jobs meant there was little time to focus on how services and teams could improve. They felt this was a direct result of staffing pressures.

Requires improvement

Are services well-led?

- There was a clearly embedded ethos of improvement in some services. This was particularly the case in cardiac rehabilitation and respiratory services, and the chronic fatigue and pain management services. Managers and staff in these services were able to describe how they worked together to identify areas of good practice and areas which required improvement. They provided examples of service improvements and explained how they monitored patient outcomes to ensure expected improvements were realised.
- We saw examples of innovative approaches to providing cardiac rehabilitation services. The cardiac rehabilitation team told us how it had worked in partnership with a private company to develop and use new technology to improve pathway tracking of patients and provide meaningful outcome data. Staff told us the information generated as a result of this project helped them to improve the services they offered to patients. The new systems and technology, they said, had improved uptake of treatment from 52% to 82%. Staff felt that the use of the new technology meant they spent less time in administrative work and more time providing direct patient care, and they were pleased with this outcome.
- There were examples of innovative responses to tailoring services around the needs of patients. This was demonstrated through the work of the diabetic team, who actively sought opportunities to support patients. There was also a wood working group, offered by the head injuries service, which was delivered with support from an occupational therapist. The rehabilitation programme offered to the group was developed to meet the needs of those with memory impairment, teaching them coping mechanisms and vocational skills. For example, patients were taught to use pictures and notes to keep track of where they finished at the end of each session and to enable them to visualise their progress through the programme.

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
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Staffing** **How the regulation was not being met:** The trust did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Supporting workers** **How the regulation was not being met:** The trust did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to patients safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal. Regulation 23(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Respecting and involving people who use services** **How the regulation was not being met:** There were unsuitable arrangements for ensuring patients' dignity, privacy and independence. Regulation 17(1)(a)(2)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Records** **How the regulation was not being met:** Patient records were not always accurate and were not always easily located. Regulation 20(1)(a)(2)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **Safety, availability and suitability of equipment** **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The trust did not have suitable arrangements to protect patients and others who were at risk from the use of unsafe equipment. The trust did not always ensure that equipment was delivered to patients when they needed it. Regulation 16(1)(a)(2) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Assessing and monitoring the quality of service provision.** **How the regulation was not being met:** The trust did not have an effective operation of systems to enable it to identify, assess, and manage risks relating to incidents and near misses relating to the health and welfare of patients and others. Regulation 10(1)(b) HSCA 2008 (Regulated Activities) Regulations 2010. Which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.