North Tees and Hartlepool NHS Foundation Trust

RVW

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RVW	Lawson Street Health Centre		
RVW	Thornaby Health Centre		
RVW	Masefield Centre		
RVW	Phoenix Centre		
RVW	Hartfields Extra Care Village		
RVW	Eaglesclife Health Centre		
RVW	Billingham Health Centre		
RVW	Tithbarne House		
RVW	Queenspark Medical Centre		

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

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

Where applicable, we have reported on each core service provided by North Tees and Hartlepool NHS Foundation Trust and these are brought together to inform our overall judgement of North Tees and Hartlepool NHS Foundation Trust >

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall we rated safety as good. There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these. Staff were able to give examples on how they had learnt from incidents and how improvements were implemented. We found there were sufficient numbers of staff to make sure that care was delivered to meet patient needs and sickness rates were below the trust target of 6%. Staff had undertaken relevant mandatory training and safeguarding training and compliance rates were above 92%.

We rated effective as good. The trust monitored and identified whether they followed appropriate NICE guidance relevant to the services they provided. The service worked in conjunction with other colleagues in the trust to develop integrated care pathways in order to facilitate the delivery of care closer to home and reduce the length of time a patient needs to remain as an inpatient. Within the therapy service patient specific outcome measures were widely used to monitor and demonstrate effective care delivery and outcomes. However, within community nursing services we found there was no formalised process for clinical supervision in place. Staff told us there were differences across the trust in how this was implemented. Some staff told us they accessed clinical supervision regularly and it worked well whereas other staff told us there was no system to access supervision.

We rated the caring domain as good. We observed care being delivered and listened to staff speaking to patients and relatives on the telephone. In order to gain an understanding of people's experiences of care, we talked to patients and their relatives who used services. During our visit we saw that patients and relatives were treated with respect, dignity and compassion and we saw caring and compassionate care being delivered. Staff were seen to be very reassuring towards patients, their relatives and other people. People we spoke with during the inspection told us they had been involved in the planning of their care.

Overall we rated the service as good as being responsive to people's needs. The trust had a range of specialist services to meet the different needs of people which included teams for diabetes, heart failure, continence, falls and neurophysiotherapy. The dementia strategy supported the specific needs of patients; the dementia strategy covered both inpatient hospital care and patients in the community. Analysis of data showed that since April 2014 the trust achieved the referral to treatment (RTT) targets of 95% for musculoskeletal (MSK) services and podiatry services. We saw evidence the service monitored these monthly and between April and June 2015 the services continued to achieve above the 95% target. The trust had in place a concerns and complaints policy and procedure. We saw there was complaints information available within the areas we visited. Learning from complaints was shared where improvements had been identified. The outcome of the investigation was shared with the patient and an action plan was prepared that senior staff shared with their teams.

We rated the service as requires improvement for well-led. We saw the service had a risk register which identified the risk rating and what control measures the service had put in place. However, on review of the risk registers the reasons why some of the risks had been put on the risk register were unclear. Some risks were classed as generic, such as the risk of dermatitis due to allergy and exposure to skin irritants and the risk of needle stick injury. These would usually be identified on an individual basis rather than as a service risk under the relevant health and safety policy / procedure. Following the inspection, the trust told us these had been put on the risk register in response to specific incidents in the HPV (Human Papilloma Virus) immunisation team and in the GP services where unsheathed needles had been used.

Staff told us on the whole they felt well supported by their managers and the senior management team within the directorate. Staff also reported they felt listened to and their managers were approachable. However, some staff told us whilst they felt supported by their direct line manager they felt management teams above them did not understand the pressures within the service. We found some staff were unclear about the nursing leadership for the district nursing service at the trust. We found reporting incidents was embedded across the

Summary of findings

service and we saw evidence of staff receiving feedback and learning was shared. We found action plans were developed following serious incidents and the actions and progress had been monitored.

Summary of findings

Background to the service

Information about the service

North Tees and Hartlepool NHS Foundation Trust (NTHFT) provide adult community services which form part of the Out of Hospital Care directorate. Adult community services are arranged and managed as three services – Adult Nursing (district nursing), the Community Integrated Assessment Team (CIAT) and Therapy Services.

The district nursing teams were an integral part of the 'teams around the practice' (TAP), with each TAP being aligned to a number of GP practices within the areas. The teams provided integrated and co-ordinated care to patients who were housebound, temporarily housebound or were receiving care by a care pathway. Adult nursing services provided wound care, palliative care support and care, to facilitate independence in daily living. The service worked alongside other health and social care professionals. The team operated 'out of hours' district nursing services between 8pm to 8am seven days a week. They covered both Hartlepool and Stockton localities.

Community Matrons worked within TAP and managed patients identified with the highest risk across the cluster; they assessed and actioned appropriate management plans to ensure maximum effectiveness for up to 12 weeks. The community matron was responsible for developing, with the patient, an appropriate management plan. This identified and addressed any specific need by co-ordinating input from other services where appropriate and by providing education around self-management and how to access appropriate services.

The heart failure team was split to cover the Hartlepool and Stockton areas; they provided a service Monday to Friday 8.30 am to 5pm (excluding bank holidays) and undertook clinics in various locations to improve ease of access for patients. The coronary heart disease (CHD) specialist nurses were split into two teams covering Hartlepool, Stockton and the surrounding villages. They provided a service Monday to Friday 8.30 am to 5pm (excluding bank holidays) and undertook clinics for review and medication management. The nurses were supported by cardiac fitness instructors to provide cardiac rehabilitation classes in community venues. The specialist diabetes nurses delivered key aspects of the diabetes pathway, in particular to facilitate early diagnosis and integrated care management for those adults with diabetes. The continence service provided an evidence based service with specialist assessment, and early intervention with the aim of preventing bowel and bladder dysfunction. This was done by developing individualised care plans for patients with diagnosed bladder and bowel dysfunction to support them in achieving a better quality of life. The service covered both the Stockton and Hartlepool localities and operates Monday to Friday 9am – 5pm.

The community integrated assessment team (CIAT) was an integrated team of therapists, nurses, therapy assistants and support workers who worked both within the acute hospital and community settings. The team worked jointly with the acute teams, community teams, social services and continuing health care services to expedite patient discharge from the acute Trust.

The aims of the emergency care therapy team were to prevent unnecessary hospital admissions and to facilitate timely safe discharges. The team provided a service to the community (crisis intervention) and hospital based care where appropriate. The physiotherapy service provided skilled assessment and rehabilitation of patients using therapists, practitioners and therapy support workers with a specialist knowledge and experience in the management of people with long term neurological conditions.

As part of this inspection we spoke with patients and relatives, nursing staff and therapists. We looked at the care records of patients and visited staff bases across the areas. Before the inspection, we reviewed performance information from and about the trust.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Helen Bellairs, Non-Executive Director, 5 Boroughs Partnership Trust

Team Leader: Amanda Stanford, Head of Hospitals Inspection, Care Quality Commission

The community services inspection team included: CQC inspectors and a variety of specialists; Health Visitors; District Nurses; Physiotherapists; Occupational Therapists; Community Matrons; Dentist and Experts by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

We inspected this core service as part of our comprehensive acute and community health services inspection programme.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well-led. We carried out an announced visit from 07 to 10 July 2015.

What people who use the provider say

Patients we spoke with were positive about the care and treatment they received. Patients and their families said that they felt supported and helped by the nursing staff who visited them.

Letters and comment cards received from patients were displayed in community locations. Throughout our inspection we saw evidence of thank-you cards the teams had received for the care and support they had given to patients and their families.

We spoke to one person who used the out of hours' service who told us: "the service had been fantastic". Another patient told us they had had a very positive experience with the district nursing service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

Summary of findings

- Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.

Action the provider SHOULD take to improve

- The trust should ensure there is a consistent approach to clinical supervision across the community adult services.

North Tees and Hartlepool NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Overall we rated safety as good. There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these. Staff were able to give examples about how they had learnt from incidents and how improvements were actioned.

We found there were sufficient numbers of staff to make sure that care was delivered to meet patients' needs and sickness rates were below the trust target of 6%. Staff had undertaken relevant mandatory training and safeguarding training and compliance rates were above 92%.

Detailed findings

Safety Performance

- The district nursing team participated in the monthly data collection of the safety thermometer which was reported as part of the nursing dashboard for community services. The dashboard was under development and highlighted the activity of the district nursing team.
- The trust reported that recent data trends showed a decrease in the number of reported harms in relation to pressure ulcers. Between April 2014 and March 2015, there were 12 new catheter urinary tract infections (UTIs). For six months in this time period there was no reported catheter UTIs however we saw between April 2014 and June 2014 and then September 2014 and October 2014, there were two UTIs reported in each of these months.

Incident reporting, learning and improvement

- There was a policy in place for the reporting and investigation of incidents: incidents were reported electronically using an online reporting system (Datix). A total of 512 incidents were reported by community health services for adults between 1 April 2014 and 31 March 2015.
- We saw from 27 November 2014 to 8 July 2015 there had been 91 moderate or severe incidents; these all related to grade 3 or 4 pressure ulcers. We found the majority of

incidents reported on STEIS were due to pressure ulcers. Information showed there has been an increase in reports of incidents with low harm, but a decrease in moderate to severe harm.

- Staff and senior managers told us there had been improved reporting on the trust's Datix incident reporting system and there was full support available from the trust's patient safety team.
- We found where needed root cause analysis (RCA) investigations had taken place. An RCA is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned. We saw as a result of the RCAs, action plans had been developed and actions monitored.
- Senior nursing managers told us outcomes from RCA reports were shared with staff and where learning or training was identified, this was provided.
- Clinical Care Co-ordinators for adult community services had a scheduled weekly meeting with the patient safety team to discuss any incidents that were reported and any actions taken. These meetings were minuted and the information was shared at monthly team meetings. We saw minutes of meetings and staff confirmed these were shared in team meetings.
- Within therapy services over the last year there had been several incidents of patients falling while rehabilitation care was being delivered. The service had undertaken work to reduce the risk by using improved risk assessments.
- We saw an example of how therapy services shared lessons learnt from incidents, complaints and risks. In February 2015 we saw information where two patients had received inappropriate treatment because they had the same name. As a result we saw that therapy services introduced three patient identifiers to be checked before assessments.
- Within district nursing services, we saw lessons learnt had been shared following an incident where the patient's relative had accidently switched off the pressure relieving mattresses. Following this the service required staff to check the mattresses and this check was then documented on the skin care bundle. In another example, because of an incident involving insulin, a checklist had now been developed and actioned.

Duty of candour

- The duty of candour regulation aims to ensure that providers are open and transparent with people who use services in relation to care and treatment. It sets out some specific requirements that providers must follow when things go wrong with care and treatment, including: informing people about the incident; providing reasonable support; providing truthful information and an apology.
- We saw patient requests were taken into account; for example, one patient had asked for a verbal update on completion of the investigation. Another patient had declined all involvement in the investigation and did not want any feedback. In both cases the patient's wishes were met.
- We saw examples of letters sent to patients/ relatives explaining the next steps and outcomes of investigations.
- Staff told us the policy regarding duty of candour had been updated and the Datix incident report had been updated to reflect the new requirements.

Safeguarding

- The trust told us and we found that all safeguarding alerts were reported through the incident reporting system and to the safeguarding team. The identified themes from safeguarding alerts raised by community nursing staff were: pressure ulcer development; concerns relating to vulnerable adults and lack of care and concerns regarding the welfare of vulnerable adults (for example people with a learning disability or dementia).
- Within adult community nursing there was a mandatory training requirement for the completion of safeguarding adults training level 1. The recent training report highlighted training figures were 92% against a target of 100%.
- In addition all staff were required to complete safeguarding children level 2 training. The most recent data showed 98% of staff had undertaken that training.
- In therapy services safeguarding training for level 1 adults and levels 1, 2 and 3 for children showed 99-100% of staff had received the training.
- Nursing staff in district nursing were able to give us an example of where they had identified a concern in relation to abuse and had referred this to the local authority safeguarding team. They were also attending a multi-agency meeting to discuss their concern.

Good

Are services safe?

- Staff told us they felt up to date with their knowledge in relation to safeguarding, mental capacity and deprivation of liberty safeguards because the training they had received kept them up to date.

Medicines

- All staff who administer medication were required to complete the medicines management workbook as part of their mandatory training requirements. We saw in May 2015, 97% of staff had undertaken medicine management training.
- The trust also provided information before the inspection which stated that the service had a number of community nurse prescribers and non-medical nurse prescribers within adult community nursing. We found at inspection that within the district nursing teams, staff were being supported to undertake extended prescribing. We found in the heart failure nursing team all staff were nurse prescribers and were expected to attend updates at least three times a year. Staff told us they received support from the trust lead for prescribing and one of the cardiologists.
- A patient group directive (PGD) is a written instruction for the administration of medicines to patients for certain conditions and in certain circumstances. For example, registered nurses were provided with a supply of doxycycline and gentamycin for administration to patients undergoing catheterisation and who were at risk of bacteraemia as part of a patient group directive.
- There were a number of PGDs in place to support the administration of influenza vaccines, pneumococcal vaccine, trimethoprim for the urinary tract infection pathway (delivered by Rapid Response Nursing Teams), doxycycline and gentamycin. The trust provided information which stated the PGDs were reviewed on a regular basis. The clinical care co-ordinators were implementing an audit to ensure all staff who would be required to follow one of these PGDs had understood and signed the documents and have completed the PGD workbook if required.
- All registered nurses within the adult community nursing service had access to adrenaline as part of the contents of the "shock packs" that were carried in the event of an occurrence of anaphylaxis by patients in the community. This stock was replenished by the Trust's pharmacy.

Environment and equipment

- The district nursing teams had a number of "kit bags" that were designed for the transportation of equipment between patient visits which complied with infection prevention and control standards. We saw the kit bags within the district nursing teams and saw they contained all the relevant equipment. However, staff we spoke with told us the bags could be heavy to carry.
- For equipment that was not single use, each team was responsible for ensuring de-contamination was carried out using the appropriate wipes.
- During our inspection, we observed staff within the neurophysiotherapy team being trained on a new piece of equipment to support care of patients.
- Staff within the out of hours district nursing team told us on occasions they had difficulty in accessing equipment which could impact on the needs of the patient. For example, staff told us of one patient who required a commode and they were unable to get this out of hours.
- Staff in all areas were able to describe the process for checking the servicing data on medical devices. We were told that servicing was completed by the Medical Physics Department. Access to syringe drivers was through the medical equipment library for both Hartlepool and Stockton localities.
- If a safety alert was issued, this was shared with service leads who prepared a response to either say that the medical device alert was not applicable to their service or an action plan was produced with time scales.

Quality of records

- We saw that within community nursing services that patients had an electronic care record and a patient held record which was kept within the patient's home. Staff told us there was minimal information held within the patient held record to minimise any differences between the two records.
- Healthcare record audits were completed on a monthly basis. A quality standards audit tool, which was in a pilot phase, had been developed to provide assurance of compliance with completion of the electronic healthcare records that were used within adult nursing. We spoke with the lead nurse who told us the audit did not look at both the electronic patient record and the patient held record stored in the patient's home.
- Information Governance training was an annual mandatory requirement for all staff within the trust.

Data showed that 95% of staff had undertaken this training. Health record keeping training was mandatory and received once; compliance in the service for this training was 97%.

- Within the neurophysiotherapy team we found they still used paper based records but we were told they were due to move onto electronic health records in the next couple of months.

Cleanliness, infection control and hygiene

- We found within the service there were the standard precautions to prevent the spread of infection. There was a policy in place to ensure that any patients with an infection were managed appropriately. We found staff had access to hand gel and were provided with sterile dressing packs which contained personal protective equipment (PPE) for staff to carry out nursing care.
- Hand hygiene compliance was monitored on a monthly basis as part of the "essential steps" audit and submitted to the Infection Prevention and Control team.
- Throughout our inspection we observed good infection control practices, such as hand hygiene and cleaning equipment between uses, was in place.

Mandatory training

- Throughout the service we found mandatory training was either through on-line training, workbooks or face to face training.
- The service had a monthly report of compliance with training requirements which was circulated by the education and organisational department within the trust.
- The report was RAG (red, amber, green) rated with individual staff highlighted as non-compliant where appropriate. This helped the team leads to identify actions to improve training levels. The report also highlighted which staff were due to complete certain aspects of mandatory training to allow for staff to plan updates proactively.
- We reviewed the report for May 2015 and found that overall 96% of staff had undertaken mandatory training.

Assessing and responding to patient risk

- The rapid response team utilised the national early warning score (NEWS) and sepsis pathway to monitor and assess deteriorating patients. Within district nursing they used initial assessments and the clinical observation process to monitor and assess patients.
- The trust reported that as part of the on-going holistic assessment process, any risk that was identified to the patient or those providing care was reported through the incident reporting system. These risks could include: the risk of pressure damage or tissue breakdown; concerns relating to potential neglect (safeguarding concerns); non-compliance with treatment or care; and exposure of patients and staff to violent and aggressive behaviour.
- The clinical care co-ordinators shared work across the teams to ensure patients were seen as their health needs required and there was an escalation process to deal with emergencies and urgent cases. However, staff told us (and we found) there was no documented process to ensure consistency across the trust on how staff dealt with workloads including urgent patients that needed to be seen. Staff in district nursing told us they used a RAG system to categorise patient needs and organise workloads; we found there was no written guidance to support the categorisation. As a result across the teams there was a potential for differences in the way teams organised and categorised patients.

Staffing levels and caseload

- There were a total of nine district nursing teams across the Stockton and Hartlepool localities with seven in Stockton and two in Hartlepool. Each district nurse had a defined caseload of patients and was aligned to a number of residential care homes within the locality which allowed for continuity of care.
- We saw there were three wte (whole time equivalent) district nurse vacancies out of an establishment of 23 wte posts. There were 1.35 wte registered nurse vacancies out of 66.45 wte posts and 1.8 wte health care assistant vacancies out of an establishment of 19 wte. Within both Stockton and Hartlepool we saw caseload sizes for district nurses ranged between 80 and 258. Senior staff told us they monitored workloads and caseloads daily when there were increased workloads and these were then shared between teams. A senior clinical matron told us the service planned to look at staffing levels, acuity and dependency within caseloads, to ensure the right skill-mix was available to manage caseloads. However, there was no timescale for when this would be completed.

Good

Are services safe?

- Within therapy services, all areas had an agreed staffing establishment however this was flexible to the needs of the service. In times of pressure, the service would use their business continuity plan to move staff around ensuring that priority areas were supported in full.
- We found the neurophysiotherapy team was fully staffed. The service lead told us they had trialled an occupational therapist (OT) within the team and this had proved to be beneficial. A business case was being drafted to submit to the trust for an OT to be permanently part of the team.
- Within the diabetes specialist nursing teams, three members of staff covered inpatient care, outpatients, education of nurses and medical staff. Staff reported the numbers of patients they covered had increased annually by approximately 1,500 and there had been no increase in staffing numbers.
- The clinical care co-ordinators monitored the activity within the individual teams on a regular basis and ensured that there was flexibility within the nursing workforce to manage any increase in demands within a particular area. This flexibility may result in the re-allocation of a patient call to another member of staff / team or moving a staff member to another team in order to maintain safe care delivery.
- Each team completed a daily sitrep (situation report) on staffing levels and calls / contacts each day. These were then submitted to the business support team and collated daily. However, there was no further analysis or monthly report of these that the service could look at to review the quality of services they provided.
- District nurses told us they were just implementing a monthly planner which would help the team allocate patients depending on their level of need/ dependency and this would help them manage workloads on a day to day basis.
- Patient care was categorised into three levels according to complexity to ensure the visit or contact was allocated to the appropriate member of staff with the right skills to undertake the care. For example, complex cases would be allocated to a band 6 member of staff whilst administering an injection would be allocated to a band 5 member of staff.
- Staff in district nursing services told us, on average, they undertook between 12-15 contacts a day. District nurses told us there was no maximum amount of contacts that staff would undertake in one day and that staff would work additional hours to make sure patients were seen.
- The therapy department average sickness rate between April 2014 and March 2015 was 4%; this was below the trust's target of 6%. All sickness was managed through the trust's attendance management policy. One of the senior staff told us that for small periods of time, teams could cope with short-term sickness but this became more problematic for longer periods.
- Following a review of the management of winter pressures within the service, a training needs analysis of all staff within the service was to be undertaken. This was being done to ensure that all staff, regardless of grade and position, were competent and safe to perform a role in ward-based care. Staff told us due to pressure within the acute hospitals, they were sometimes asked to work on wards to relieve some of the staffing pressures.

Managing anticipated risks

- We spoke with staff who mainly worked alone in community settings about the service's lone working procedures. Staff working from community locations were encouraged to develop local procedures within their team.

Major incident awareness and training

- The directorate held monthly resilience meetings and members of the group were notified of any planned exercises within the trust.
- We found there was a business continuity plan in place for all of the adult nursing services which was reviewed on a regular basis. Each service also had its own local business impact assessment plan in place to identify critical functions within each service; this linked into the corporate business continuity plan.
- The district nursing service told us the policy for major incidents were available on the intranet and there was a major incident training session planned.

Good

Are services effective?

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

Summary

Overall we rated the service as good for the effective domain. The trust monitored and identified whether they followed appropriate NICE guidance relevant to the services they provided. The service worked to develop integrated care pathways to facilitate the delivery of care closer to home and reduce the length of time a patient needed to remain as an inpatient. Within the therapy service patient specific outcome measures were widely used to monitor and show effective care delivery and outcomes.

However, we found there was no formalised process for clinical supervision within community nursing services. Staff told us there were differences across the trust in how this was actioned. Some staff told us they accessed clinical supervision regularly and it worked well whereas other staff told us there was no systems to access supervision.

Detailed findings

Evidence based care and treatment

- District nurses carried out an initial assessment to assess the individual needs of patients and facilitate appropriate planning of care, in line with local policies and guidelines.
- The district nursing service submitted annual data to the NHS benchmarking network which meant the service contributed to the national picture of services and took part in a forum to share best practice.
- Community services worked jointly with the medical directorates in the trust to develop integrated care pathways to facilitate the delivery of care closer to home and reduce the length of time a patient needed to remain as an inpatient. For example, there were pathways for the delivery of intravenous antibiotics within the home, and a venous thromboembolism pathway to provide care safely to patients with a diagnosis of deep vein thrombosis or pulmonary embolism.
- The rapid response team gave intravenous antibiotics to patients at home as part of the cellulitis pathway to enable patients to be discharged home earlier and reduce the length of their hospital stay.
- We saw the CIAT team followed NICE guidance for falls assessment by using a multifactorial risk assessment tool. The tool also included: a screen for bone health; a mental health screen; and an assessment of social needs. Staff we spoke with told us the effectiveness of the service had improved and referrals had increased following the falls audit.
- We saw the guidelines used by the diabetes service were dated 2012 and currently under review; however there was no date for completion.

Nutrition and hydration

- Community services used a recognised needs assessment tool supported by national guidance to assess patients' nutrition and hydration needs.
- Within the district nursing service we found they utilised the malnutrition universal screening tool for assessing and reviewing patients' nutritional status. If a patient was assessed as being at risk of poor nutritional intake, the community nursing teams would refer patients to dieticians or the patient's GP.
- The district nursing service also provided support for patients who needed artificial feeding by a feeding tube in the patients' stomach.

Technology and telemedicine

- The CIAT team introduced telephone consultations to streamline risk assessments for patients who were more able than others. This was available for patients who were 65 years and over. The team sent out a self-assessment pack which also included an equipment assessment.
- The district nursing teams had access to mobile devices so they could view patient records whilst in the patients' home. However, many staff we spoke with told us there were often issues with connectivity resulting in them being unable to view the records.
- We spoke with the senior management team who told us there was a project taking place to review this to

allow staff to download the record prior to the visit. In the meantime, if staff needed any information they could not access, they could contact the single point of access.

Patient outcomes

- The senior management team told us there was a plan to develop the community nursing dashboard to provide a tool to demonstrate effective care delivery and outcomes.
- CIAT services measured patient outcomes. For example, they used tools such as: Eoroqol (an intermediate care tool that measures patients' perceptions of their own function, pre- and post-intervention); the abbreviated mental test (AMTS); 'fear of falling' analogue tool and a case management risk scoring tool. This followed NICE guidance for managing fall risks and included completion of a pre-determined risk assessment that produced a risk score pre- and post-intervention. The scores should show the risk of falling reduced post-intervention. Staff we spoke with confirmed they used these to care for patients.
- Patient specific outcome measures were widely used within therapy services. The 'EQ-5 tool' included an assessment of walking, activities such as leisure and housework and pain and discomfort. We saw these were monitored on the directorate dashboard to ensure compliance with commissioner targets. For example, in March 2015, we saw 100% of patients had been assessed using the EQ-5 tool. We saw for each month between April 2014 and March 2015, more than 90% of patients had achieved an improvement from their initial assessment.
- Therapy services measured patients well-being prior to attending and on discharge from the spinal rehabilitation programme using: the 'Roland Morris disability evaluation tool', the 'Owestry disability index' and the 'hospital and anxiety and depression scale'.
- The continence team had recently carried out an audit into the assessment of faecal incontinence to ascertain adherence to NICE guidance CG49. One of the actions from this audit was to develop document templates to ensure all of the elements of the NICE guidance were part of future assessments. The continence service was planning to develop templates as part of the roll out of the electronic patient record system, 'SystmOne'.
- There was an audit programme for district nursing which included: health care record audits; annual health and safety audits; catheter audits; leg ulcer audits and screening audits. In addition we saw the CIAT audit plan included a timetable and notes on progress.

Competent staff

- Staff within community nursing services told us, within their service, there was no formalised process for clinical supervision in place. Staff told us there were differences across the trust in how supervision was carried out. Some staff told us they accessed clinical supervision regularly and it worked well whereas other staff told us there were no systems to access supervision.
- All therapy services staff had an identified mentor or supervisor within the service. Although formal supervision did not necessarily happen on a monthly basis in all areas of the service, staff were encouraged to informally seek advice when needed.
- Staff had an individual training needs analysis to ensure they undertook training relevant to their role. We saw there was a range of role specific training available for staff. For example, we saw 85% of staff had received level 3 dementia training and 95% had training on falls. Whilst only 39% had received training on the safe use of insulin and 67% of staff had received training on acute illness management. These were against targets of 90-95%.
- Within the diabetes specialist nursing team staff had undertaken further training and two out of the three staff had a qualification in diabetes management.
- The dementia service had developed a competency framework in line with national guidance on dementia care. Training and workbooks were changed to reflect this.
- The heart failure nursing team provided quarterly updates / education sessions for staff at North Tees to update their knowledge and skills.

Multi-disciplinary working and coordinated care pathways

- We were provided with and observed a range of evidence which showed how services worked with other agencies to meet the needs of patients and to ensure patients, relatives and carers were supported. This

included joint working with GPs, occupational therapists, physiotherapists, social workers, community psychiatric nurses, and tissue viability nurses as well as local hospices.
- Community matrons were allocated a group of patients with long term conditions and worked with the GP practices to assess and provide a management plan that would prevent hospital admission. Staff told us most GP practices were working on SystmOne which meant they could communicate electronically from the patients' records.
- The rapid response team worked closely with the emergency assessment unit and ambulatory care to identify patients who could be safely cared for within their own home. This team also worked closely with the district nursing team to provide support to those patients who required extra support, because of acute illness or palliative care diagnosis.
- The CIAT team told us they tried to be involved with multi-disciplinary ward rounds but this was sometimes difficult due to gaps within staffing and finding cover.
- For the last few years, the neurophysiotherapy team worked jointly with leisure services to provide an exercise programme and peer group meetings. A new business case had been developed to extend this to include a gym, a community village and group forums.

Referral, transfer, discharge and transition

- Access to the community nursing service was by a referral to the single point of access (SPA). Within SPA, there was a standard operating procedure for district nursing with a decision grid to support the timeliness of referrals.
- All patients that were receiving end of life care from the district nursing service would also be referred to the out of hours service so they were aware of the patients' needs and requirements should they require further support out of hours.
- Staff told us there had been some examples of poor discharges from the hospital wards and these had been reported as incidents. Senior managers told us there was on-going work with wards to improve discharges and address the issues and this was now improving.
- There was an open referral system to the neurophysiotherapy team; referrals were received from hospitals, GP's, self-referral and community matrons.
- The service was working with local GP's on admission avoidance strategies and were identifying the appropriate referral pathways to community matrons or district nursing teams. Further work was needed on agreeing referral criteria for patients with long-term conditions.

Access to information

- Information was available to staff through the trust intranet to support practice. Staff briefings were available through the intranet, with links to new policy documents.
- Staff reported that they had access to information for each patient, which included medical and nursing records and results from any investigations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found consent training was a mandatory requirement for all staff who work within the trust. We saw 97% of community adult service staff had undertaken the training. We saw all care plan templates had consent included.
- The trust had policies and procedures for mental capacity and deprivation of liberty safeguards. The Adult Safeguarding team provided on-going support and education to the community nursing teams in relation to this area of practice.
- District nursing staff told us where they identified issues regarding patients' mental capacity; they would work with the patients' GP to undertake a mental capacity assessment.

Seven day services

- The district nursing teams provided a 24 hour, seven day service (with out of hours support provision from an established out of hours nursing team). The rapid response team worked seven days per week between 8pm to 8 am.
- The community matron teams and specialist nursing teams (incontinence, heart failure, coronary heart disease, and specialist diabetes nurses) provided a service Monday to Friday (excluding bank holidays).
- Staff had access to the on-call manager outside of normal working hours; this allowed staff to escalate any concerns in a timely way to prevent and manage any risks that had developed.

Good

Are services caring?

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

Summary

We rated the caring domain as good. We observed care delivered and listened to staff speaking to patients and relatives on the telephone. In order to gain an understanding of people's experiences of care, we talked to patients and their relatives who used services. During our visit, we saw that patients and relatives were treated with respect, dignity and compassion and we saw compassionate care being delivered. Staff were seen to be very reassuring towards patients, their relatives and other people. Patients we spoke with during the inspection told us they had been involved in the planning of their care.

Detailed findings

Compassionate care

- As part of our inspection, we observed care delivered and listened to staff speaking to patients and relatives on the telephone. In order to gain an understanding of people's experiences of care, we talked to patients and their relatives who used services.
- During our visit we saw that patients and relatives were treated with respect, dignity and compassion and we saw compassionate care being delivered. Staff were seen to be very re-assuring towards patients, their relatives and other people.
- When delivering care and treatment, staff respected patient confidentiality. Confidentiality was maintained in discussions with patients and their relatives and in written records or other communications.
- We observed care and treatment being delivered by community nursing and specialist nursing staff to patients in several home settings. Care was delivered sensitively and effectively in a caring and appropriately responsive way. Staff respected and maintained the patient's dignity.
- We spoke to one person who used the out of hours' service who told us: "the service had been fantastic". Another patient told us they had had a very positive experience with the district nursing service.

Understanding and involvement of patients and those close to them

- We observed staff speak with patients in a kind and respectful manner. We also saw staff explain the reason for the visit and what care would be undertaken if the patient agreed. Patients we spoke with during the inspection told us they had been involved in the planning of their care.
- Staff told us (and we saw) care plans were completed with the patient. The plans in therapy services included outcome measures which were patient orientated. They asked the patient and their relatives their views about their care each day and included this information into their care plan.
- One patient was supported with artificial feeds by the district nurse team. We saw the team had complied with the patient's preference for a morning visit; this was an example of how the team respected the patient's wishes and preferences.

Emotional support

- Staff we spoke with were patient, focused and offered support to help patients cope with their care and treatment.
- Throughout our inspection we saw evidence of "thank-you" cards received by the teams for the care and support they had given to patients and their families. In one card it stated: "You all brightened his day with your care and cheerful ways. We couldn't have kept Dad at home without you all."
- In another card we saw written: "Thank you so much to the whole team for the care and kindness you showed my Mum."

Good

Are services responsive to people's needs?

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

Summary

Overall we rated the service as good for being responsive to people's needs. The trust had a range of teams providing specialist services to meet the different needs of people including: diabetes; heart failure; continence; falls and neurophysiotherapy. The dementia strategy supported the specific needs of patients. We found the dementia strategy covered inpatient hospital care and patients in the community.

Analysis of data showed that since April 2014, the trust achieved the referral to treatment (RTT) target (95%) for musculoskeletal (MSK) services and podiatry services. We saw evidence the service monitored these monthly and between April and June 2015, the services continued to achieve above the 95% target.

We saw there was complaints information available within the areas we visited**.** The trust had in place a concerns and complaints policy and procedure. Where improvements were identified through complaints, learning was shared. The outcome of complaint investigations was shared with the patient and an action plan prepared that senior staff shared with their teams.

Detailed findings

Planning and delivering services which meet people's needs

- Managers we spoke with described their approach to planning and delivering services that were responsive to the needs of patients. Staff told us that they worked with local commissioners of services, the local authority, other providers, GPs and patients to co-ordinate and integrate pathways of care.
- Services included specialist nurses and therapists for particular conditions, for example teams dealing with diabetes, heart failure, continence, falls and neurophysiotherapy.
- In the neurophysiotherapy team, we found they provided services for people who had multiple sclerosis, Parkinson's disease and Huntington's disease.
- Specialist teams provided services in the community that met patient needs closer to home and were accessible. Community nursing teams addressed the needs of patients who were assessed as predominantly housebound or where needs were identified as best being met in their own home. For patients who were more mobile and able to travel to local centres, the service operated some community clinics. For example, the heart failure nursing team ran a monthly patient support group with additional support from dieticians, pharmacists and health trainers.
- When we visited a residential care home with the district nursing team, the manager of the home told us the team were very responsive and would prioritise their work to meet the needs of the patients. Care planning was informed by holistic needs assessments and liaison with other health professionals.

Equality and diversity

- The trust provided information which showed in May 2015, 97% of staff had received bullying and harassment training which included equality and diversity training.
- Translation/interpreter services were available to patients whose first language was not English. Staff told us they were able to use a telephone interpreting service if required.
- We observed that information leaflets were available for patients, but these were not readily available in languages other than English.

Meeting the needs of people in vulnerable circumstances

- The dementia strategy supported the specific needs of patients. We found the dementia strategy covered inpatient hospital care and patients in the community. The community matron service had started to undertake dementia screening with patients in the community.
- Staff told us they had received additional workbook training on caring for people living with dementia. The service had developed specific care pathways and there were dementia champions in each team.
- The dementia team had developed a one-to-one service where a group of three band one support workers were employed to provide support to a patient with cognitive or neurological impairment. This support was provided

Good

Are services responsive to people's needs?

24 hours a day seven days a week and included cognitive stimulation and was focused on the individuals' needs. The result had been a reduction in patient aggression and falls.
- The services had regular discussions with patients' GPs to ensure needs of vulnerable patients were met. Staff told us they were able to check on the GP register for vulnerable patients.
- Staff told us they could utilise a learning disability passport with patients who had a learning disability and would try to support the patient with continuity of care by assigning staff who knew their needs.

Access to the right care at the right time

- We saw between April 2014 and March 2015, the referral to treatment (RTT) target (95%) was achieved by the musculoskeletal services and podiatry services. We saw the service monitored performance monthly and between April and June 2015, the services continued to achieve above the 95% target.
- We were told there had been an increase in referrals to the falls service following implementation of NICE guidance on falls.
- At the time of inspection, the neurophysiotherapy service had appointment waiting times of seven weeks. The team received between 20-30 patient referrals each month.
- Staff in the team told us they triaged and prioritised referrals to ensure the most urgent cases were seen sooner. Staff also reported they tried to be as flexible as possible with appointments for patients.
- Therapy services staff supported and encouraged patients to self-manage their own care through information leaflets and through appropriate websites.
- There were two service level agreements for the single point of access to answer 50% of calls within 15 seconds and the remainder within 30 seconds. We saw data which showed that (with the exception of February 2015) between December 2014 and June 2015 the targets had been met.

Learning from complaints and concerns

- The trust had in place a concerns and complaints policy and procedure. We saw there was complaints information available within the areas we visited.
- Staff in district nursing teams told us where patients did have concerns they would try to resolve these locally first and records were kept of informal complaints on a complaints log.
- For formal complaints, patients who had concerns were encouraged to contact the single point of access or the patient experience involvement team.
- Where improvements were identified through complaints, learning was shared. The outcome of complaint investigations was shared with the patient and an action plan prepared that senior staff shared with their teams.

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.

Summary

We rated the service as requiring improvement for being well-led. We saw the service had a risk register which identified the risk rating and what control measures the service had put in place. However, on review of the risk registers, there was duplication of some risks and some risks were classed as generic such as the risk of dermatitis due to allergy and exposure to skin irritants and the risk of needle stick injury. We would expect these to be related to a specific incident or trend rather than as a generic service risk under the relevant health and safety policy/ procedure. Following the inspection, the trust told us these had been put on the risk register in response to specific incidents in the HPV (Human Papilloma Virus) immunisation team and in the GP services where unsheathed needles had been used.

Staff told us on the whole they felt well supported by their managers and the senior management team within the directorate. Staff also reported they felt listened to and their managers were approachable.

However, some staff told us they felt supported by their direct line manager but that management teams above them did not understand the pressures within the service. We found some staff were unclear about the nursing leadership for the district nursing service at the trust. There was a culture of support and openness within the service and staff felt supported to raise concerns.

Detailed findings

Service vision and strategy

- We spoke with the senior management team who told us the overall vision for the service was to: provide care closer to home; to reduce length of stay in hospital; and to avoid hospital admission.
- We found the service was working with their commissioners to try and reduce variations between Stockton and Hartlepool. For example, the opt-in service was different between the two areas.
- The senior management team also told us they were keen to work with other partners and agencies to support patients with the common purpose of keeping patients safe at home.
- The district nursing teams were aligned to GP practices to form teams around the practice (TAP). The senior management team told us these had been influenced by GP's and had been introduced as a result of changes through transforming community services in 2011.
- The dementia service staff told us they felt involved in the development of the service and felt their voice was heard.

Governance, risk management and quality measurement

- We saw the service had a risk register which identified the risk rating and what control measures the service had put in place. For example, we saw a potential risk had been identified for missed district nursing visits and the measures the service had put in place to reduce the initial risk rating score of 12 to a residual risk score of four.
- However, on review of the risk registers, it was unclear why some of the risks had been put on the risk register. For example, some risks were classed as generic such as the risk of dermatitis due allergy and exposure to skin irritants and the risk of needle stick injury. We would expect these to be related to a specific incident or trend rather than as a generic service risk under the relevant health and safety policy/ procedure. Following the inspection, the trust told us these had been put on the risk register in response to specific incidents in the HPV (Human Papilloma Virus) immunisation team and in the GP services where unsheathed needles had been used.
- We also found duplication of risks for some areas of the service. We found there were two risks on the register for adult nursing and district nursing in relation to pressure ulcer damage for patients. There were also two risks in relation to documentation in patient records.
- We saw that resource to support the falls service was identified as a red risk for the service and there was a business case in place to review this.

Requires improvement

Are services well-led?

- We saw within adult services there were adult patient safety meetings. We saw minutes of these meetings where incidents, risks, policies, safeguarding, complaints and patient safety concerns were discussed. For example, we saw the last six months of minutes and found in the minutes of the meeting on 21 May 2015, a message was shared with staff following a recent safeguarding concern: staff were required to document in the patients' care records any advice given to care home staff about the patients' care.
- We found reporting incidents was embedded across the service and we saw evidence of staff receiving feedback and learning was shared.
- We found action plans were developed following serious incidents and the actions and progress had been monitored.

Leadership of this service

- Staff told us on the whole they felt well supported by their managers and the senior management team within the directorate. Staff also reported they felt listened to and their managers were approachable.
- However, some staff told us they felt supported by their direct line manager but that management teams above them did not understand the pressures within the service. One member of staff told us they felt like a "payroll number" to the organisation. We found some staff were unclear about the nursing leadership for the district nursing service at the trust.
- We were told band 6 nurses met with their line managers on a weekly basis and feedback was shared through the daily meetings with the rest of the team.
- Within the community matron services some staff told us they hadn't felt supported by their line manager and the trust when they had raised concerns about a particular GP practice and this still had not been resolved.

Culture within this service

- We observed staff working well together and there were positive relationships within the multidisciplinary team.
- Most staff told us there was a culture of support and openness within the service and they felt supported to raise concerns. Staff reported they were encouraged to report incidents and there was a no blame culture within the organisation.
- We found the service had local lone-working guidelines. Staff within the out of hours team told us they always worked in pairs when visiting patient homes.
- The senior management team told us further work was planned to encourage the workforce across the organisation to work more closely together and with social care.

Public engagement

- The trust told us a patient experience project has been running within outpatient physiotherapy for the past two years. This involved engaging with service users through focus groups to understand their perceptions and experiences of the physio department. A number of key trends were identified. An action plan was produced which resulted in staff attending customer care training; the development of a patient information leaflet; and improvements to the pre-attendance letter to better inform patients of the assessment process. Further focus groups are planned for the future to ensure developments are made in line with patient expectations.
- At the time of inspection there was no formal measurement of patient outcomes in relation to patient satisfaction; however there was a plan to implement the friends and family test for community nursing.
- Patient feedback surveys were undertaken throughout the year in neurophysiotherapy services. These had highlighted concerns regarding parking issues and the number of disabled parking spaces. As a result of the feedback, another parking space had been created.
- Services undertook staff patient experience quality team (SPEQ) questionnaires and audits. These involved: looking at hygiene; the environment; speaking with patients; and reviewing their records. Outcomes were highlighted and we saw letters from the director of nursing to matrons with the feedback.

Staff engagement

- Staff told us community services had integrated with the community trust in 2008 and they felt communication and engagement with the acute side of the trust was improving.
- During the inspection we held staff focus groups and staff told us they generally enjoyed working for the trust, felt supported and were encouraged to learn and develop.

Requires improvement

Are services well-led?

- Staff told us they felt listened to and they could influence changes to the service or organisation.

Innovation, improvement and sustainability

- The service was developing a better care fund development plan which would look at closer working with the local authority and shared patient records.
- Within the neurophysiotherapy team they worked jointly with leisure services to provide an exercise programme and peer group meetings. A new business case had been applied for to extend this to include a gym, a community village and group forums.

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(b)** • Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.