

Bradford District Care Trust

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# Community health services for adults

## Quality Report

New Mill  
Victoria Road  
Saltaire  
Shipley  
West Yorkshire  
BD18 3LD  
Tel: 01274 228300  
Website: [www.bdct.nhs.uk](http://www.bdct.nhs.uk)

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This report describes our judgement of the quality of care provided within this core service by Bradford District NHS Care 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 Bradford District NHS Care Trust and these are brought together to inform our overall judgement of Bradford District NHS Care Trust

# Summary of findings

## Ratings

Overall rating for Community health services for adults

Requires Improvement



Are Community health services for adults safe?

Good



Are Community health services for adults caring?

Good



Are Community health services for adults effective?

Requires Improvement



Are Community health services for adults responsive?

Requires Improvement



Are Community health services for adults well-led?

Good



# Summary of findings

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# Summary of findings

## Overall summary

Bradford District Care Trust provides a range of community health services for adults with long-term conditions. These include district nurses, community matrons and community clinics, such as podiatry, speech and language therapy, leg ulcer clinics and continence clinics.

Overall, patients received safe care across all services and teams. Patients and relatives told us that they were treated in a caring and friendly way and were kept informed. In general, we found that there were enough staff for the service to be safe. While there were vacancies in some community teams, the number of staff on duty was monitored to make sure that the service was flexible and met patients' needs. Recruitment for staff vacancies was on-going. The senior managers and district nurses we spoke with confirmed that they met regularly to discuss the number of staff and what support was required across the different teams.

Arrangements were in place to manage and monitor infection control, medicines and the safeguarding of people from abuse. There were also dedicated teams to make sure that policies and procedures were implemented. For example, the safeguarding lead told us that the safeguarding team undertook record keeping audits to check that policies and procedures were complied with. In addition, there were measures in place to minimise risks to patients, for example pressure ulcers. These measures included using the NHS safety thermometer tool to monitor and analyse patient data on harm-free care.

Staff knew how to report incidents, near misses and accidents, and were encouraged to do so. However, we found that learning from incidents, and the sharing of learning within teams and across the organisation, was inconsistent.

Services were effective, evidence-based and focused on patients' needs. There were also examples of staff working well together.

We saw some excellent practice from the district nurse team and in the clinics we visited, where staff provided

compassionate and individualised care that promoted independence. Staff were aware of the emotional aspects of caring for people living with long-term health problems, and made sure that specialist support was provided where needed. The patients we spoke with were positive about the services and said that the care they had received was good and met their needs. Patients also told us that staff involved them in decisions about their care and treatment.

The majority of staff were up-to-date with mandatory training and there were systems in place to make sure that they received appraisals. However, we found that the clinical and reflective supervision of staff varied across the community nursing teams.

Patients, their carers and/or families were encouraged to provide feedback about their care and treatment, and we saw examples where feedback had been used to develop the service. There were also complaints procedures available and complaints were handled effectively. Staff across the services told us that they offered patients choices about where they wanted to be treated, and there were, for example, community clinics for wound management.

Managers and staff understood the roles and responsibilities of governance and quality performance. While most staff were aware of the trust's vision and strategy, this was not embedded across the service. In addition, some staff were unaware of the issues about quality that were affecting their service.

There was a positive culture, where staff were encouraged to raise problems and concerns without fear of being discriminated against. However, some staff told us they did not always get feedback about the problem or concern they had raised.

Community team managers provided good leadership and support, and most staff felt engaged with their line managers. However, some staff told us that they felt disconnected from the trust's board, although they did acknowledge that this had improved recently.

# Summary of findings

## Background to the service

People with long-term conditions received services from district nurses and community matrons in their own home. There was also a range of clinics in the community that offered specialist services such as podiatry, speech and language therapy, leg ulcer clinics and continence clinics.

As part of our inspection we visited clinics and we accompanied district nurses and community nurses on

home visits to talk to patients and their relatives about their experiences. We spoke with 48 patients and relatives in clinics, by telephone and during observed visits to people's homes.

We interviewed 111 staff across all designations and roles. This included qualified nursing staff, specialist nurses, health care support workers, student nurses, allied health professionals, team leaders and managers. Some interviews were conducted on a one-to-one basis, while group discussions were arranged as focus groups.

## Our inspection team

Our inspection team was led by:

**Chair:** Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

**Team Leader:** Jenny Wilkes, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission (CQC)

The team included inspectors, inspection managers, Mental Health Act commissioners, a pharmacist inspector and an analyst.

We also had a variety of specialist advisors, including district nurses, tissue viability nurses, community matrons, a rehabilitation specialist and Experts by Experience.

## Why we carried out this inspection

Bradford District Care NHS Trust was inspected as part of the second pilot phase of the new inspection process we

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

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

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

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

# Summary of findings

We carried out an announced visit of community health services for adults with long-term conditions between 16 and 20 June 2014. Before visiting, we reviewed a range of information we hold about Bradford District Care NHS Trust and asked other organisations to share what they knew about the provider. During our visit, we held focus groups with a range of staff, including district nurses, health visitors and allied health professionals. We observed how people were being cared for and talked with carers and/or family members. We also reviewed the personal care or treatment records of patients.

As part of our inspection we visited clinics and we accompanied district nurses and community nurses on home visits to talk to patients and their relatives about their experiences. We spoke with 48 patients and relatives in clinics, by telephone and during observed visits to people's homes.

We interviewed 111 staff across all designations and roles. This included qualified nursing staff, specialist nurses, health care support workers, student nurses, allied health professionals, team leaders and managers. Some interviews were conducted on a one-to-one basis, while group discussions were arranged as focus groups.

## What people who use the provider say

We spoke with a range of patients and relatives during the inspection. We gathered comment cards from patients and relatives during the week of the inspection. The majority of people we spoke with were positive about the care and treatment they received.

## Good practice

We found that the working women's service provided effective, multidisciplinary support for people who used the service.

The podiatry team used real-time survey information to make improvements to the services.

## Areas for improvement

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

The trust should improve staff awareness of the Mental Capacity Act 2005 and how it is used to support people who use services.

The trust should ensure that staff report all delays in referrals from the administration hubs to community teams working with adults with long term conditions, monitor performance in regards to referral delays and take expedient action to address poor performance.

The trust should improve the effectiveness and analysis of the safety thermometer data and audits so that improvements in practice can be made as a result of the findings.

Bradford District Care Trust  
Bradford District NHS  
Care Trust

# Community health services for adults

**Detailed findings from this inspection**

The five questions we ask about core services and what we found

Good 

## Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

### **Incidents, reporting and learning**

Most staff were aware of the process for investigating when things had gone wrong, including the use of root cause analysis (RCA) to investigate serious untoward incidents. A serious untoward incident is an event which has the potential to produce, unexpected or unwanted effects involving the safety of patients. It therefore includes accidents, clinical incidents, security breaches, violence, and any event which does or could result in harm. Staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic system and were encouraged to do so. Staff also told us there were guidelines available for them to follow within the incident reporting system and as part of their induction they were able to practice completing incident forms in prior to reporting live incidents. We found practices to share information and learning across the organisation were variable, with some district nursing teams unaware of

lessons learnt and improvement actions to take. We were told the trust had recently introduced risk guardians in localities whose role was to ensure risks were escalated appropriately.

Staff reported there was an open culture in the organisation which encouraged them to report concerns and incidents. For example, changes had been made to the way pressure ulcers were investigated with the emphasis on learning rather than blame and supporting staff to address areas for action within their teams. We looked at one patient's care and treatment records and saw they included the actions from an RCA and the actions had been implemented. We saw the findings of the RCA indicated a reassessment of the patient's pressure areas and a nutritional risk assessment were required, and this had been completed. We saw as a result care plans had been reviewed and updated and referral to the tissue viability service was in progress.

# Are Community health services for adults safe?

One of the district nurses we spoke with explained to us the actions taken after a drugs error had been discovered. In this case a pharmacist had prescribed the wrong dosage of insulin. This incorrect dosage had then been administered by the district nurse team for a week before a district nurse on the out-of-hours team had identified the error. On this occasion no harm had been caused to the patient. We were told that following this incident learning was disseminated to all the district nurse teams. Staff had been reminded to take care and follow medication administration policies.

Some staff reported they received feedback from incidents during team meetings and handovers. Senior nursing staff reported they shared learning at sisters meetings and did this across the district. We reviewed the minutes of the district wide sisters meeting for May 2014. We saw a discussion had taken place into the reporting of 'near misses' on the electronic incident reporting (IRE) system. A near miss is an unplanned incident that did not result in injury, illness or harm but had the potential to do so. We saw information on which sections of the IRE system staff had been advised to complete.

We spoke with the head of service for Bradford district who told us that staff were encouraged to report staff shortages on the IRE system. Staff we spoke with confirmed they had been advised to do this.

## Cleanliness, infection control and hygiene

There were policies and procedures in place for the prevention and control of infection which were based on the Department of Health's guidance 'Essential steps to safe clean care'. Staff reported they had received infection control training. We saw from training figures the trust provided that 82% of staff across the trust had completed infection prevention. However, we could not identify from the information for example how many staff had completed infection prevention training in podiatry services.

In accordance with infection prevention and control practices, we saw there were effective systems and processes in place to dispose of clinical waste and sharps. We observed staff carried out regular hand hygiene practices and 'bare below the elbow' guidance was followed, along with the wearing of personal protective equipment, such as gloves and aprons, while delivering care.

## Maintenance of environment and equipment

Overall, we saw the public areas and clinical environments in the community premises we visited were modern, appeared clean and uncluttered and were in a good state of repair. We found premises had procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. Procedures were in place to ensure equipment was regularly maintained and fit for purpose. We saw equipment was regularly tested and maintained to ensure it remained fit for purpose and safe to use. We found patients were provided with information that detailed the procedure for equipment repairs and reporting of faults out of hours.

District nurses told us they carried a sharps bin in their car when visiting patients in their own homes. When we accompanied district nurses to visit patients in their own home we saw staff used the sharps bins in an appropriate manner and the sharps bins were fit for purpose.

Staff told us equipment to assist people in their own homes such as commodes and walking aids were supplied in a timely manner from a central community store location. However, staff also told us they had experienced delays in deliveries of non-stock items, such as wound drains, and these had been ordered through the administration hubs. Staff told us that on occasions patients had waited four to five days for the right equipment to be delivered. This meant there could have been delays in the appropriate treatment being delivered to the patient.

## Medicines

We found there were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. Systems were in place to reflect on learning from adverse events, incidents and near misses related to medicines so the risk of them being repeated was reduced.

Autonomous nurse prescribers in community are a distinct group of nurses who are allowed to independently prescribe from a limited formulary called the Nurse Prescribers' Formulary for Community Practitioners. This formulary includes over-the-counter drugs, wound dressings and applications. We found that community matrons and district nurses were autonomous prescribers. They told us there was a prescribing lead for nurses, and they attended nurse prescribing courses, which included updates, such as antibiotic prescribing. They also told us

# Are Community health services for adults safe?

they were able to access GP training material, and if they had a practical issue with medications they would speak with the GP at the practice they were linked with. We saw from the records we looked at that autonomous prescribers reviewed medication they had prescribed to ensure it remained effective.

## Safeguarding

There were effective safeguarding policies and procedures, which were understood and implemented by staff. Staff were aware of the trust's whistleblowing procedures and the action to take. There was a Safeguarding lead that provided a range of expertise, support, and advice to all staff. Staff confirmed they had completed safeguarding training. We saw a training matrix which highlighted staff who worked in community were required to undertake safeguarding adults training however we did not see information on how many staff had completed this training.

## Records

We found that staff used an electronic patient record, but that they needed to print off records to take to the patient's home. We also found staff were duplicating daily entries in the care records – one in handheld record and one in the electronic record. This meant the records took staff longer to complete and there was a potential entries in the records may not match as they were completed at separate times.

The trust was in the process of introducing a system called 'agile working', which included community staff having access to laptops so they could look at and complete patients record in their own home. We spoke with staff who were using the devices as part of the trials of the new equipment. They told us they were useful although there were issues with the power supply as they became very hot when being used and connectivity to the internet. One community matron told us they would make notes during the consultation in the patient's home, and then make the entries onto the device when they were back at base. However we found most staff did not have this equipment and did not know when this would be available to them.

## Lone and remote working

There were systems in place to promote the safety of staff when lone working. Staff told us that they would go in pairs for high-risk visits. We saw that reporting systems were in place to ensure the whereabouts of staff were known and staff were provided with mobile phones and personal alarms.

## Assessing and responding to patient risk

We found all teams in the community were aware of key risks such as falls and pressure care. We saw that risk assessments were completed and staff responded to findings by referring people for additional assessments or for relevant equipment.

## Staffing levels and caseload

Staffing levels were generally safe and, while there were vacancies in some community teams, there was on-going monitoring to make sure that staffing levels were flexible and met the dependency needs of patients. Recruitment processes were on-going to fill staff vacancies. Community nursing staff in a number of localities told us they were carrying a number of qualified staff vacancies as well as having to cover for planned and unplanned leave. One locality team told us staffing levels were entered onto the risk register. Another locality had recently experienced a rapid turnover of its permanent staff and this team was being covered by the trust's relief team. In addition, one of the other localities also provided support to the workload of this team. We found there was no information which showed this had affected patient care. Staff we spoke with confirmed they would "go the extra mile to make sure patients got the care they required."

The majority of the community staff told us that the case loads at week end and out-of-hours was high. Some of the staff reported of having to cover caseloads of up to 19 visits in the day at weekends. This often led to staff not taking statutory meal breaks and rushing between appointments. We looked at information from the trust's computer system we saw the number of visits undertaken and the number of staff planned to work on each weekend during June 2014. However, we found this information did not identify what staff actually worked at the weekend. Therefore we did not see any information on how absences would impact on the number of visits staff would be required to undertake. We also found the trust were not monitoring this to support staff in managing their workloads particularly on a weekend.

We looked at staffing in the podiatry and speech and language therapy (SALT) services and found there were enough staff to meet people's needs. Staff we spoke with told us there were absences in the services however there were measures in place to manage this. For example in podiatry services there were two 'roving' podiatrists who would cover services across the district.

## Are Community health services for adults safe?

We spoke with the head of service for Bradford district care trust who confirmed that staffing shortages within the community nursing teams were on the trust's risk register. They told us that they were in the process of recruiting seven new staff, with plans to recruit a further five staff to fill the remaining outstanding vacancies. They felt that they would be able to take this issue off the risk register in July. Staff we spoke with told us they were aware the trust were recruiting to the vacant positions and felt they were doing their best to obtain a full staffing complement.

### Deprivation of Liberty safeguards

We found trust policies and procedures were accessible to staff via the trusts electronic computer drive. The majority of staff told us that they had received training on both the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). We saw a training matrix that highlighted staff who worked in community were required to undertake mental capacity and DoLS training, but we did not see information on how many staff had completed this training.

The DoLS should ensure that when a patient is deprived of their liberty this is done in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. Staff we spoke with were able to describe when DoLS would be used in different care settings.

Patients we spoke with told us staff explained options regarding their care and treatment. We observed staff

discussing options with patients while they delivered care, in order for them to make informed choices about their care and treatment. We also observed staff obtained verbal consent before undertaking treatments for example, wound dressings and injections.

### Managing anticipated risks

We found there were systems and processes in place to maintain patient safety. There were specialist nurses who offered a range of services in the community teams to meet patients' needs, for example pressure ulcers. We saw the nurses undertook individual assessments and planned care to meet people's needs. This meant people with long-term conditions were triaged and assessed accurately so that safe treatment and care was provided to protect against the risks associated with their complex condition. Risk assessments in areas such as falls, nutrition, and pressure care were completed and updated as patient's needs changed.

### Major incident awareness and training

Business continuity plans were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery. A trust assurance process was in place to ensure compliance with NHS England core standards for Emergency Preparedness, Resilience and Response.

We found contingency plans were in place in the event major events, such as outbreaks of flu or winter weather which may affect staff's ability to travel. Staff told us they were aware of the contingencies in place to manage events, such as the potential disruption of the Tour De France cycle race. A number of staff raised issues about staffing levels particularly at weekends.

# Are Community health services for adults 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.

## Evidence based care and treatment

We found that individual roles and responsibilities were understood by staff in the delivery of evidence-based care. This included involvement in the development of policies and procedures, and in the assessment and monitoring of the quality of care provided to adults with a long-term condition. Care pathways demonstrated they had referred to NICE (guidance issued by expert body, the National Institute for Health and Care Excellence) guidelines to ensure patients were appropriately assessed and supported with their needs. We saw care plans referred to NICE guidelines and trust policies and contained specific information on the patient's physical needs.

Community staff used nationally recognised assessment tools in order to screen patients for certain risks, and referred to relevant codes of practice, for example infection control and falls assessments.

During our conversations with staff on the Mental Capacity Act (MCA) 2005, they provided us with varying degrees of awareness. For example, case managers were able to describe in more detail how they were involved in working with the multidisciplinary team to assess people's mental capacity. However, some staff had limited knowledge of MCA procedures and its relevance for community services. These procedures protect the rights of adults using services by ensuring that if there are concerns regarding their ability to understand and make decisions relating to their care. These are then assessed by professionals who are trained to assess the person's capacity to make decisions and whether a best interest meeting is needed.

Most staff told us they were unclear of what assessment was needed but would refer on to mental health services or a GP to undertake the assessment of a person's mental capacity. We spoke with some staff who told us that despite the training they did not feel confident enough to undertake assessments. We also spoke with the head of service for Bradford district care trust who told us they felt the training was to a high standard and they would expect community matrons and district nurses to perform assessments under the Mental Capacity Act 2005.

We spoke with staff who were able to verbally identify patients who had fluctuating mental capacity on their caseloads. When we looked at care records we found there was no place to record the person's mental capacity status. We also found following a mental capacity assessment information on the person's mental capacity was not transferred into the person's care plan. For example, if a patient had fluctuating mental capacity where they could make some decisions but not others this was not recorded in the care records. This meant out of hours staff who did not know the caseloads would not be able to easily identify the patient's mental capacity from the care records.

We did not monitor responsibilities under the Mental Health Act (MHA) 1983 at this location, but we examined the trust's responsibilities under the MHA at other locations and we have reported this within the overall trust report.

## Pain relief

Records showed that patients were provided with options and information relating to pain relief. Patients who required pain relief had pain assessment charts in place, which included end of life tools, such as symptom control management.

We observed two qualified district nurses' introduce a syringe driver safely within a patient's own home. We also observed the district nurses' discussing with the patient their pain relief. They also assisted the patient to request their GP to visit so that they can discuss their pain relief requirements.

## Nutrition and hydration

We saw nutrition and hydration assessments were completed on all appropriate patients. These assessments were detailed and used nationally recognised nutritional screening tools.

Two of the patient records we looked at on the person's electronic care record included up-to-date malnutrition risk assessments and care plans to assist the patient with their activities of daily living. The records also included support from other health professionals as determined by the risk assessments for example, the patients GP, dietician, tissue viability and palliative care specialists.

# Are Community health services for adults effective?

## Patient outcomes

We saw evidence community teams monitored the performance of their treatment and care. Transition arrangements were effective across services with appropriate referrals and the provision of key information.

We spoke with one district nurse who explained how they would assess a patient, who required dressings and treatments for a wound. As well as assessing the patient's general condition, they would undertake a clinical assessment of the wound. This would include a physical examination and the taking of photographs so that the healing process could be mapped over time. Dressings were undertaken as directed within the trust's formulary. In complex cases, where treatment outside the formulary was indicated, they would discuss this with the trust's tissue viability nurse.

We were told the speech and language therapy team had devised a telephone triage system, which made service delivery and planning more effective. Those referrals which required extensive, long-term input were identified and fielded accordingly, while referrals requiring less extensive input were dealt with more efficiently. This meant the waiting lists were organised dependent on treatment longevity and costing, which made planning and service delivery more efficient. Systems were reviewed to ensure clearly-identified need was being met.

## Performance information

The trust used the NHS safety thermometer, which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. The NHS safety thermometer is designed to measure a monthly snapshot of four areas of harm. These are: the assessment and treatment of patients with venous thromboembolism; catheter-related urinary tract infections; new pressure ulcers; and falls. The trust sent us the results for district nursing services that showed between 90% and 100% harm-free care was achieved in most localities.

We were shown the system and process for inputting the safety thermometer data and we saw the team leaders were entering the data monthly. However, there was no evidence available to demonstrate the effectiveness and analysis of the safety thermometer data. Senior staff confirmed the trust did not provide the community teams

with any analysis and outcomes from the data supplied. This meant the service did not routinely analyse the information to identify themes, trends or areas for improvement.

Staff also told us they completed a medicines' thermometer, which identified how medicines had been prescribed, and could pick out information as to whether they had been prescribed correctly. Staff we spoke with told us they got feedback from the data gathered from this reporting tool and it was available on the trust's intranet.

Team leaders we spoke with were aware of the Commissioning for Quality and Innovation (CQUIN) data. However, there was no evidence locally available to demonstrate the effectiveness and analysis of this data. This is another example of how the service did not use information to identify themes, trends and areas for improvement.

## Competent staff

The majority of staff told us access to mandatory training had improved including specialist external courses. Records showed over 84% of staff had completed mandatory training and over 83% had received appraisals in the last 12 months. These figures were trust-wide and did not indicate data for specific service types. All staff we spoke with confirmed they had had an appraisal within the last 12 months and most staff thought it was a supportive and valuable process.

Staff experience of clinical or reflective supervision was variable across community nursing teams and some staff did not access regular protected time for facilitated, in-depth reflection on clinical practice. Staff told us this was done in ad hoc manner within their teams as there were also not enough clinical supervisors across the trust. This meant staff did not have dedicated time to reflect on their practice and identify any learning points from clinical issues which arise.

## Use of equipment and facilities

We found equipment was available for use and reflected good practice. We spoke with both community matrons and district nurses who told us that they have a 'PIN' number, which allows them to access equipment from a supplier who works with the trust. They told us the equipment arrived in good time and if the specific equipment they ordered was not immediately available the suppliers would source similar equipment.

# Are Community health services for adults effective?

## **Multi-disciplinary working and working with others**

Through our observation of practice, review of records and discussion with staff we found effective multidisciplinary team working practices were in place. Staff told us there was effective communication and collaboration between teams and other health providers met regularly to discuss any changes to the care of patients.

We found different professionals within the trust worked well together and there was very good engagement and evidence of good working relationships with other health, social care providers and the police in order to manage and meet people's needs. Occupational therapy and physiotherapy services were provided by the local acute trust and these professionals did not have access to the patient records on electronic system. Therefore the service relied on paper-based records in relation to these aspects of the patients care. We found both these groups of professionals were involved in the monthly multidisciplinary team meetings.

Patients who received care and treatment for long-term conditions told us that staff communicated well with their GP and other professionals. They gave examples of how community staff had referred them to other services, support and advice groups or had arranged other professionals to carry out assessment visits.

We spoke with district nurses who told us how they worked as a multidisciplinary team when caring for patients with complex and long term conditions. One nurse explained how they would discuss patients with Parkinson's disease with a specialist nurse, while they also linked in with heart failure nurses and mental health nurses.

We spoke with a community matron who told us how they worked with the mental health team at the trust to ensure the admission of a patient with a mental health condition continued to receive care for their physical health needs. This was an example of how the service worked in partnership to meet people's needs.

Staff we spoke with raised concerns with the discharge information that had been provided when a patient returned home from hospital. Patient discharge information did not always include information about the patient's GP or information on new medications or treatments prescribed. We found the trust had started to have monthly discharge meetings with external providers to look at improving information sent at the time of discharge.

## **Co-ordinated integrated care pathways**

Staff told us they had developed good links with a range of key professionals and understood each other's roles. Care records showed the involvement of other agencies in providing integrated care pathways. This meant care was well co-ordinated and planned to meet people's needs.

# Are Community health services for adults caring?

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

## Compassionate care

We observed positive interactions between staff and patients in a number of different care settings. Patients were treated with compassion and empathy. We observed staff speaking with patients and provided care and support in a kind, calm, friendly and patient manner.

The patients we spoke with were complimentary about staff attitude and engagement. Patients said they received very good care. One patient told us, "The podiatry service was excellent" and another patient said, "The district nurses were all exceedingly pleasant and kind. Couldn't have had a better experience." District nursing staff reported, "We are very good at patient care and we cover the cracks. We stay as long as the patient's needs." District nursing staff we spoke with told us they "were proud of the care we give."

One community nursing team told us how they now used a more wide-ranging and holistic approach to care planning. This incorporated practical support to the patient including working with the other health professionals, social care and the police to support people to improve their lives. This is an example of how the service worked with other professionals to meet the individual needs of patients.

## Dignity and respect

We observed staff treated patients and their relatives with dignity and respect. We found patient confidentiality was respected when staff delivered care, in staff discussions with patients and their relatives and in any written records or communication.

## Patient understanding and involvement

Patients and relatives we spoke with all indicated that they were involved in care decisions, and records we reviewed confirmed this. All records we looked at contained evidence of consent from patients for treatment. We found all the services delivered person centred care and that people, their relatives and/or representatives were involved and central to decisions made about the care and support needed.

There was an interpretation service available for staff to access which included language line and interpreters who would attend visits and appointments as necessary. This meant the service took into account people's different needs when accessing services.

## Emotional support

Patients and relatives told us they were well supported. We observed staff used a holistic approach encompassing physical, social and spiritual well-being and this was incorporated into care planning. Within the working women's service there was support for women who had suffered bereavement among their peer group. The service had implemented a paper brick where women wrote messages and these were displayed on a wall. This was an example of how the service had changed practice to support patients' emotional and psychological needs.

## Promotion of self-care

Patients we spoke with told us community nurses, therapists and matrons visiting them actively promoted their independence and provided meaningful information about self-care. For example, we saw staff actively showing people how to care for their wounds. A number of patients we spoke with told us staff had provided both verbal and written information to promote their self-care. Patients also confirmed they felt actively involved and consulted about their care and treatment.

We saw information leaflets were provided to patients for health promotion and self-management of their conditions, including the prevention of pressure ulcers, podiatry advice and self-administration of medicines, such as insulin and inhalers. Some information was available in other languages but not all leaflets were. We were told the trust was reviewing what information was available to address this.

# Are Community health services for adults responsive to people's needs?

Requires improvement 

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

## Service planning and delivery to meet the needs of different people

Managers we spoke with for each service were aware of the risks in their areas such as staffing levels and skill mix, geography of the various sites and investment in community services.

The trust employed a range of specialist teams to support staff in the community to ensure patient needs were met. These included continence nurse specialists, falls teams and therapists. We found patients were able to self-refer too many of these services.

We spoke with district nurses who told us that, in order to ensure that each patient was getting appropriate and holistic care, they would undertake an assessment of activities of daily living. This would identify not just clinical information but also information on their social habits. In one case this meant a note being put on a patient's record to ensure they were not visited before 11am.

## Access to care as close to home as possible

Patients and relatives told us services were accessible and tailored by staff to meet their individual needs, at the times and in the places to best suit their lifestyle. We observed areas of good practice to ensure patients were managed in their own home.

Speech and language therapy and podiatry services were provided in a range of community settings across the Bradford district to facilitate access for patients close to their homes. Details of the venues with times and dates were available on the trust's website and available at the community practices. Patients were provided with information and support they needed to stay at home. For example, case managers worked closely with individual patient's families and carers to provide equipment and professional support to help people to stay within their own homes.

We were told the podiatry service had received overwhelmingly positive feedback from its client group. There had been 'a small number of complaints' received and these were described to relate to 'waiting times' only.

## Access to the right care at the right time

We found that community services were provided in people's home as needed, and clinics and groups were established in community locations. Community staff provided us with examples of how they changed their visits to suit the needs of the patient. For example, patients would frequently ring to change their visit times on the day of the visit and this was accommodated in the visit scheduling. Home visits by other professional could also be arranged on request.

## Flexible community services

District nurses told us they covered a large geographical area. They told there were some identified challenges to provide flexible services in the rural areas. Staff told us the distance between sites meant patients sometimes had longer waiting times particularly during winter months. There were also some challenges regarding access to electronic systems as not all staff had access to 'agile working' and those that did experienced connectivity issues. We were told the trust was working on addressing these issues.

The trust had recently moved administration support to an administration hub. This was a central call facility for single point of access (SPA) for services across the trust. The SPA dealt with healthcare professional referrals, direct health advice for patients, messages for community nurses and appointments for clinics.

We reviewed a staff information leaflet that explained they had moved from 15 separate administration teams, supporting clinical teams across 45 locations, to a pooled administration support in six locations. Community staff we spoke with were aware of these changes and the reasons for them but some staff told us they now received less administration support than they had in the past. Community nurses we spoke with told us they would sometimes obtain administration support from clerical staff in GP practices (these clerical workers are not employed by the trust).

Community nursing teams identified the SPA service as a continuing risk, which affected the flexibility of community services. The teams remained concerned about possible delays of patients being seen, confusion for patients trying

# Are Community health services for adults responsive to people's needs?

Requires improvement 

to contact them at weekends and out-of-hours, and ensuring that SPA gave patients the correct information. Staff told us ordering specialist equipment, such as specialist drains required to care for patients, could take up to eight weeks to be available because they were ordered through the SPA. Some patients we spoke with found it difficult to contact district nurses through the SPA. One patient told us they had contacted the SPA to arrange a podiatry appointment and was offered one at a centre she couldn't get to.

We reviewed incidents for community services from 1 February 2014 to 18 June 2014 and found that 22 (six per cent) incidents related to concerns about the SPA service. These included incidents where information about patient visits had not been passed onto community nurses. One incident described where a patient had been left sitting on a toilet for over two hours before staff were contacted.

We received information from the trust in relation to the measures they had taken and planned to take to reduce the risks identified. We saw on the information the trust provided staff had now been given direct telephone numbers extensions for other members of the team. In addition, a fault had been identified on the workflow management system and this system was checked daily to ensure patients weren't missed. However, staff we spoke with were not aware of the changes made by the trust and therefore these changes had not been embedded in practice.

We spoke with the head of service for Bradford District care trust who told us there were staff who worked on the single point of access out-of-hours contact service who spoke Urdu and Punjabi. However, they told us that they could not guarantee there would always be somebody on duty with these language skills. SPA is a number patient's dial to obtain urgent assistance, including out-of-hours. It is not considered good practice to use relatives to translate for patients because of confidentiality issues, and also because medical terminology requires specialist translation skills. This meant the service did not respond to the diverse needs of the local population of Bradford.

Staff were willing to allow the changes to develop so they could see how they worked in the long term. They also told us they were dependent on the successful full implementation of 'agile' working, with community staff using wireless technology and electronic work books.

We found district nurses provided a service throughout the week, including Saturdays and Sundays, while all other services were covered by a centrally based out-of-hours team. This team had, since March 2014, been contactable on a single point of access phone number and was based at the trust's Lingfield House location. The team worked between the hours of 4pm and 7am and consisted of call handlers and a district nursing team. Community staff we spoke with felt the clinical staff on the out-of-hours team provided a very good service.

The head of service for Bradford District care trust told us that following analysis of performance data they were in the process of training health support workers, using Calderdale competencies, to work within the out-of-hours team to support service delivery.

## Meeting the needs of individuals

Patients reported they had individual care plans and had been involved in the development of these. The records we reviewed demonstrated that care had been planned around the needs of the patient and their family. A range of leaflets about care and treatment was available in different formats and languages and services had access to interpreters and a telephone interpreting service.

We spoke with one healthcare assistant who also provided translation services for patients who spoke Urdu and Punjabi. They had originally been employed to provide translation services only, but had received training from the trust so that they could also provide care and treatment. There were two staff employed in this role who worked with the community nurses. They told us their specific understanding of the community allowed them to explain the choices and care options available to patients so they would feel empowered to make choices about their healthcare. They felt previously some patients had not been aware of the services available to them and therefore had not accessed the right care when they required it.

## Moving between services

There was continuous assessment of patient needs using the single assessment process, with patients and carers to facilitate decisions regarding future care. Community matrons told us they provided assessment and diagnosis in conjunction with GPs and nurse prescribers to ensure patients received care which met their needs following discharge. There was good collaborative working between services to ensure continuity of care.

# Are Community health services for adults responsive to people's needs?

Requires improvement 

## **Complaints handling (for this service) and learning from feedback**

Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at service level or through the trust's patient advice and liaison service. Training for staff on complaints was provided. Learning from feedback was evident and improvements had been made in areas such as communication for patients being discharged from intermediate care.

During our visit to a number of localities the senior team leaders told us complaints received at local level were infrequent. Any concerns raised in the community or at clinics were dealt with at local level. Any learning from significant complaints were discussed at monthly governance meetings and brought back to the locality teams for dissemination at team meetings.

# Are Community health services for adults 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.

## Vision and strategy for this service

The vision and values of the organisation were displayed in clinical areas. Locality managers described areas such as meeting the needs of patients, promoting a learning culture and continuous development as the priorities for the future. We found managers and some staff were aware of the organisation's vision and strategy, however this was variable and not fully embedded among all teams.

## Guidance, risk management and quality measurement

Risk management and quality assurances processes were in place at a local level. Adult community services held governance and patient safety meetings and records showed risks were escalated and included on risk registers and monitored each month. We found that managers were aware of the quality issues affecting their services and some shared this with staff. Although we found understanding of quality measures was variable among different teams.

The trust had provided data regarding the number of grade 3-4 pressure ulcers identified in the community. Community staff felt there had been significant learning and felt there had been improvements in the management of pressure ulcers as a result.

In some community teams, staff told us that there were not enough staff and they were working additional hours regularly. This meant that supervision meetings were difficult to achieve on a regular basis. Senior managers and staff told us recruitment had started to resolve this issue.

## Leadership of this service

Staff we spoke with said that they received good leadership and support from their immediate line manager. Some staff told us members of the trust board were visible and had accompanied them on patient visits. Other staff we spoke with told us they felt disconnected from trust's board although they acknowledged this had improved recently. Staff confirmed there were monthly formal cascade processes including messages from the chief executive and board of directors.

## Culture within this service

The trust engaged with staff through quarterly staff surveys, and weekly bulletins. Most staff reported a positive shift in culture in the organisation. They reported increased engagement and felt they were being listened to. Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority. Staff told us they were encouraged to raise concerns about patient care and this was acted on.

We found some district nursing teams worked in silos, which meant sharing of best practice and concerns between teams wasn't as effective as it could be. Figures showed staff sickness levels were within expected numbers in most areas with higher than average sickness rates in community nursing services. The majority of staff told us morale had improved following recent culture changes within the service.

## Public and staff engagement

Records showed that services sought feedback from patients who received care in community settings or in their homes. Patient surveys had been undertaken in respiratory, podiatry and district nursing services. Results from the surveys showed patient feedback was positive. In clinical areas, we saw feedback forms were available for patients to provide comments, concerns and compliments. We also saw patients were encouraged to attend service events.

Most staff told us staff engagement had improved. However, we found there was some variance in practice with regards to communication and some community nurses said they did not feel engaged with senior managers in the organisation.

## Innovation, improvement and sustainability

The working women's service had been awarded a respect award and £1,000. They had used the money to set up a craft group to design a 'bag of inspiration', which was sold through the Bradford care shop. Money from the sales had been re-invested into the craft group who were now designing a calendar.

## Are Community health services for adults well-led?

We found the podiatry service had introduced real time surveys of patients who used the service. Information was used to identify improvements for the services provided.

The health on the streets team provided positive health messages and organised a games-themed swimming event for older people in the community.