Airedale NHS Foundation Trust

RCF

Community health services for adults

Quality Report

Airedale General Hospital Skipton Road Steeton
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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)
RCF	Airedale General Hospital		

This report describes our judgement of the quality of care provided within this core service by Airedale 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 Airedale NHS Foundation Trust and these are brought together to inform our overall judgement of Airedale 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?	Outstanding

Summary of findings

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Summary of findings

Overall summary

Overall, we found services for community adults to be good.

There was a good culture of incident reporting. Staff received feedback and there was evidence of shared learning and responding to incidents to prevent reoccurrence. Staff understood their role with regard to keeping patients safe. They knew about the different types of abuse to look for and how to raise a safeguarding concern. There was excellent compliance with adult safeguarding training. We observed good infection control practices and compliance with mandatory training was high, exceeding the trust target in all areas but one. Staff were aware of the key risks to patients and how to detect if there was deterioration in a patient's condition. Risk assessments were completed thoroughly with actions clearly documented to reduce risks. Staffing levels were good and staff said their workload was manageable. Community staff received excellent clinical support from advanced nurse practitioners.

Community services for adults worked with pathways based on National Institute of Clinical Excellence (NICE) guidelines and took part in local and national audit. We saw effective use of telemedicine. The digital care hub housed the intermediate care hub, the gold line service which provided care for patients in the last 12 months of their life, and the telemedicine service. Patient outcomes were measured at both local and service level. We saw examples of positive patient outcomes following intervention from community services. Staff appraisal rates were high at 89% and staff received regular supervision. Advanced Nurse Practitioners (ANPs) provided advice and support for staff caring for patients with complex conditions. We saw many examples of multidisciplinary and multi-agency working in order to provide effective care for patients. The Craven collaborative care team were a multi-professional team, which included mental health nurses and social care workers. Access to information was good. Patient records were held on the same electronic system used by the hospital and by most GP practices in the area. This allowed for sharing of information and good communication between health care staff. There was a plan to improve this further with agile working.

Caring was good. Patients we spoke with were happy with the care they received and told us staff were kind and supportive. We observed staff treating patients with dignity and respect. Teams had dignity champions whose role was to challenge poor care and promote dignity. Staff provided holistic care. There was a focus on promoting independence and enabling patients to manage their long term conditions. There was emotional support available for patients and carers. Mental health nurses worked in the collaborative care teams and could offer assessment and treatment to patients with mental health conditions. Specialist nurses were able to give emotional support to patients and their families. They also referred patients to other organisations able to offer support.

Friends and Family Test data for community services showed consistently high scores of between 95% and 100% for patients who would recommend the service to their friends and family.

Community services for adults were responsive. There was close working with commissioners to provide services to meet the needs of the local population. Services were planned in conjunction with the acute hospital, and other agencies to provide integrated care to patients. We found some good examples of services responding to the needs of a diverse population. An interpreter was present at the cardiac rehabilitation exercise classes and there were women only hydrotherapy sessions available. Community services for adults were extremely accessible and timely. The telehealth service provided immediate access to expert opinion and diagnosis and was available 24 hours a day, seven days a week. Staffing at the hub was increased in the evenings, on weekends and bank holidays when demand was highest. The needs of vulnerable people were met. Mental health nurses were based in the collaborative care teams and could provide mental health support for patients. Teams had a dementia link person who attended the dementia focus group and shared information with the teams. The service received a low level of complaints and a high level of compliments. Staff told us they tried to deal with informal complaints as early as possible before they escalated.

Summary of findings

We found community services were extremely well led. Senior managers shaped their services to meet the overall trust vision of 'Right Care'. Services were being developed and transformed to ensure that patients received care closer to home. Clear governance arrangements were in place with risks assessed, documented and control measures implemented. Community services produced a monthly quality account dashboard, which showed performance against patient safety, clinical effectiveness and patient experience indicators. We found strong leadership at local and senior level. Staff spoke highly of their managers and told us they often saw them and they were approachable. Managers told us they were extremely proud of their staff. There was patient involvement in focus groups to develop new pathways of care and the service participated in the Friends and Family Test. Staff were highly engaged. They enjoyed their work and were patient centred in their approach. They told us they felt valued, supported and well managed. We found a culture of continual service improvement and innovation with a willingness to embrace new ways of working.

Summary of findings

Background to the service

Community services joined the Trust in 2011 as part of the transforming community services programme designed to move care out of hospitals and closer to people's homes. Community adults services employed approximately 225 whole time equivalent staff.

Community services were managed within the integrated care group, which was aligned with diagnostics.

The trust provided community adult services at 11 different sites serving the population of Airedale, Wharfedale and Craven. Services were delivered in community hospitals, clinics and patient's homes. Services included, community nursing (Craven locality only), therapy services and specialist nursing in heart failure, cardiac rehabilitation, lymphoedema, neurology and respiratory care. Collaborative care teams provided intermediate care using a multi-disciplinary/multiagency approach. Therapy services, which included community rehabilitation teams, were also provided across the Bingley area.

During our inspection, we spoke to 32 members of staff including, nurses, health care support workers, therapists, managers and administration staff. We observed care being provided in patient's homes. We spoke with 10 patients and looked at 10 patient records. We also reviewed performance information from, and about, the trust.

Community Services had not been inspected previously although Airedale General Hospital was inspected in September 2013 as part of the pilot scheme for a new system of inspections.

Our inspection team

Our inspection team was led by:

Chair:

Team Leader: Cathy Winn, Care Quality Commission

The team included CQC inspectors and clinical specialists including a specialist physiotherapist and a community nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive 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.

Summary of findings

What people who use the provider say

Friends and Family Test data for community services for 2015 was consistently good with services scoring between 95% and 100% for patients who would recommend the service to their friends and family. The most recent score we looked at was for February 2016, which was 96%.

Good practice

- Telemedicine services provided at the digital care hub were outstanding. The telemedicine service provided remote video consultations between Airedale staff and patients in their own homes, care homes and in prisons. Clinical staff in the hub received calls from staff in care homes and could speak to residents directly whilst viewing them on the screen. They provided advice and support on the most appropriate action to take. If necessary, they could call for emergency services on the patient's behalf whilst continuing to give advice and reassurance. This service was available 24 hours a day 365 days a year.
- We thought the collaborative care teams were an outstanding example of a multidisciplinary team working. The teams worked across acute and community services and in collaboration with other agencies to provide a responsive service for patients 24 hours a day, 7 days a week. The teams aimed to support patients in crisis to remain in their own homes and avoid unnecessary hospital admission as well as supporting early discharge from hospital.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve:

- Staff should use interpretation services to communicate with patients and not rely on family members to translate information for patients.
- The duty of candour should be fully embedded in the organisation at all levels.

Airedale 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

We rated the safety of community adults services as good because;

- There was a good culture of incident reporting. Staff received feedback and there was evidence of shared learning and responding to incidents to prevent reoccurrence.
- Staff understood their role with regard to keeping patients safe. They knew about the different types of abuse to look for and how to raise a safeguarding concern. There was excellent compliance with adult safeguarding training.
- We observed good infection control practices and compliance with mandatory training was high, exceeding the trust target in all areas but one.
- Staff were aware of the key risks to patients and how to detect if there was deterioration in a patient's condition. Risk assessments were completed thoroughly with actions clearly documented to reduce risks.
- Staffing levels were generally good and staff said their workload was manageable. Community staff received clinical support from advanced nurse practitioners.

However;

- Some staff we spoke to had an awareness and understanding of the Duty of Candour but this was not consistent across all staff.

Detailed findings

Safety performance

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harm. The improvement tool focuses on four avoidable harms, falls, pressure ulcers, urinary tract infections in patients with a catheter (CUTI) and venous thromboembolism (VTE).
- We looked at the safety thermometer data for community adult services for the period January 2015 to January 2016 and found that there had been 24 falls with harm, 91 pressure ulcers (category 2 -4) and 10 new CUTIs reported within this period. Community services did not collect data on VTE.

Good

Are services safe?

- Community services were not yet able to benchmark this data nationally or against other organisations, however managers told us the data was discussed at caseload meetings to identify themes which may require preventative action.

Incident reporting, learning and improvement

- Community services used an electronic reporting system to record incidents.
- Staff understood their responsibilities to raise concerns and to record safety incidents. They understood how to report incidents using the electronic reporting system.
- There was an open culture of reporting incidents in community services and there were systems in place to learn from incidents and reduce the chances of them happening again.
- Staff confirmed they received feedback from incidents and any learning was discussed at staff meetings and shared across all teams. They said managers responded quickly to incidents to prevent reoccurrence. An example of this was community nurses reported an incident when equipment had not been available for a patient. In response, managers had quickly ordered additional equipment.
- Managers told us they looked at all incidents to identify trends and themes so they could take preventative action.
- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There had been no never events reported for community services for adults.
- Between 1 February 2015 and 31 January 2016 there were 140 incidents reported on the National Reporting and Learning System (NRLS) for community adult services. This included those reported for community inpatients. Most of these incidents were classed as no harm however, 16 were classed as low harm and two were moderate harm.
- Serious incidents are incidents that require further investigation and reporting. There were three serious incidents reported in the service between February 2015 and January 2016. All serious incidents were investigated using a Root Cause Analysis (RCA) process.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Most staff we spoke to had an awareness of the Duty of Candour however, this was not consistent across all staff. Once we explained what the duty of candour was to staff who did not know, they all said that they acted in accordance with it and would always apologise to their patients if they caused them harm.
- Two managers we spoke to knew about the duty of candour and could give examples of when this should be applied.
- Community nurses told us that they were encouraged to be open and honest when they made mistakes.
- We saw a 'Being Open' policy, which included the process for Duty of Candour. This was available on the staff intranet however; most staff we spoke to were not familiar with it.

Safeguarding

- Community staff had a good knowledge and understanding of safeguarding and could give examples of the types of abuse they needed to look for.
- Staff understood their role with regard to keeping patients safe. They were aware of the reporting mechanism for safeguarding issues and knew that they could contact the trust safeguarding team if they needed advice. A nurse gave an example of a recent referral to safeguarding, as there were concerns about the behaviour of a patient's husband.
- Staff said they had good links with the local authority for safeguarding.
- Training levels for safeguarding were high in community services. Information supplied by the trust for January 2016 showed that compliance in safeguarding adults was 97%, safeguarding children level one and two were 94% and 100% respectively. This meant that all safeguarding training levels exceeded the trust target of 80%.

Medicines

- Staff in the collaborative care teams told us that they worked with patients to help them understand how to take any new medication they have been prescribed whilst they were in hospital.

Good

Are services safe?

- We observed two patient medicines charts and saw that these were fully completed and had been signed and dated by staff.
- A manager told us that a new medicine chart was being rolled out and that there were good relationships with the pharmacy team.
- Staff in the collaborative care teams carried adrenaline in their domiciliary bags when visiting patient's at home. We checked the adrenaline in domiciliary cases in the storeroom and found it was in date. However, one health care support worker we accompanied on a patient visit said that she was aware the adrenaline in her case was out of date and she planned to replace it when she returned to her office base.
- Antibiotics for patients on the intravenous cellulitis pathway were stored in the fridge at Skipton hospital. They were in date and we saw that the fridge temperature was correct and had been recorded daily on the log sheet.
- Advanced Nurse Practitioners (ANPs) worked in community services and were qualified independent prescribers.

Environment and equipment

- Staff told us that availability of equipment was generally good. If staff had any issues about equipment, this would be flagged with team leaders who sorted it out very quickly. Staff said that more equipment had been purchased this year and patients who were fast tracked received their equipment within six hours of request.
- We observed the equipment store for the Craven collaborative care team and found that it was well stocked with walking frames, shower boards, bedpans and commodes. They were in good condition and looked clean. However, the storage room they were kept in was an old brick building in the grounds of Skipton hospital, which appeared damp with black patches on the walls.
- Equipment had been electrically tested and the dates the items next needed to be serviced were recorded to ensure that they were maintained in line with manufacturers' recommendations. All equipment we saw was within the service date.
- We saw that sharps were safely managed and disposed of in line with health and safety regulations. Sharps bins were correctly labelled and dated.
- The trust did not own some of the buildings from which community services were delivered. A service level agreement was in place between the trust and the property owner. There were several issues identified with some buildings, which had been risk assessed and escalated to the property owner.

Quality of records

- Patient records were held on an electronic record system. There were some paper notes kept at patient's homes but these were minimal.
- We looked at 10 patient records and found that they were completed accurately and thoroughly.
- Care plan audits were regularly carried out. We saw in the minutes of the Airedale collaborative care team meeting that the audit results were discussed.
- Information governance training levels for January 2016 was 84% for staff working in community services. This exceeded the trust target of 80%.

Cleanliness, infection control and hygiene

- Training compliance for infection prevention and control level one and two was 92% and 88% respectively for January 2016.
- We saw evidence of monthly hand hygiene and reusable equipment audits in community nursing. Information was displayed on notice boards in staff offices and showed good compliance
- Staff carried personal protective equipment (PPE) such as gloves and plastic aprons with them when visiting patients at home. We saw staff washed their hands and used hand gel prior to and following patient contact.
- We observed good infection prevention and control practice. Wounds were redressed using aseptic technique.
- Each team had an infection control link person who attended regular link meetings and fed information back to their team.

Mandatory training

- Information supplied by the trust showed that compliance with mandatory training was high. The overall total for community services for January 2016 was 91%. All areas of mandatory training exceeded the trust target of 80% with the exception of consent training, which was 67%.
- Staff we spoke with said they were up to date with their mandatory training. They said their mandatory training record was stored on the electronic staff record and they

received an email alert reminding them when their training was due. Part time staff said they sometimes found it difficult to find time to complete all their training.

Assessing and responding to patient risk

- Community nursing teams used the National Early Warning Score (NEWS) to identify deterioration in a patient's condition. Depending on the NEWS score there were trigger pathways for staff to follow an escalation process.
- Community staff we spoke with were aware of the key risks to patients. For example, risks of falls and pressure damage to skin.
- The community nursing teams completed risk assessments for patients as part of the core patient assessment. Risk assessments were carried out to identify patients at risk of falls, pressures ulcers, pain and malnutrition. Staff were aware of what action to take to protect patients from these risks and we saw this clearly documented in the notes. Staff were aware of how to refer patients on for specialist assessment or for the supply of additional equipment to manage these risks.
- We looked at 10 community nursing patient records and found that risk assessments had been thoroughly completed and documentation was in line with professional standards.

Staffing levels and caseload

- There were 10.2 whole time equivalent staff vacancies out of a total establishment of 224.5 in community adult services at the end of October 2015. This represented a less than 5% vacancy rate.
- There were three community nursing teams in the Craven virtual ward, South Craven, North Craven and Crosshills. The level of registered nurse vacancies in the Craven virtual ward was listed on the risk register. A risk assessment had been completed and actions taken to mitigate the risk to patients and reduce the stress levels for staff.
- The trust had funded five additional community nursing posts to support community nursing teams under pressure. Managers said that recruitment to band five and six district nurses was challenging and reflected the national picture.
- Advanced Nurse Practitioners (ANPs) worked within the community teams. Staff in the community nursing teams told us that having the ANPs in their team had made a positive difference and they felt very well supported by them.
- Crosshills community nursing team told us that they had approximately 400 patients on their caseload, which was held on the electronic system. They explained that some patients on their caseload might also be receiving care from the collaborative care teams as they shared care depending on the patient's needs.
- Healthcare support workers we spoke with said they felt their caseload was manageable. If they finished their visits early, they would phone round the team and help them with their visits.
- Community services had created a workforce development plan for district nursing. We saw this had been discussed in the minutes of the November board meeting.
- Nursing staff told us that responding to increasing complexity of patient need in the community was a challenge.
- There were two collaborative care teams. The Airedale and Wharfedale team were managed together and the Craven team was managed separately. Staffing levels were generally good. The Craven team had 23 staff and no vacancies. The Airedale/Wharfedale team had three staff vacancies, one support worker and one advanced nurse practitioner and one physiotherapy rotational post. This team also had four staff going on maternity leave in the near future.
- Collaborative care teams had an escalation process for when demand on the service was greater than capacity. We saw that communication and working relationships were good across these teams.
- Capacity and demand work was ongoing for the Craven virtual ward and the collaborative care teams to establish future demand and inform workforce planning.
- Therapy staff told us they felt their caseloads were manageable as long as they could prioritise. They could not foresee how many referrals they would receive therefore had processes in place with a capacity tool to cope with demand. They told us that current staffing levels felt safe.
- The telemedicine service was staffed by band 6 and band 7 qualified nurses. At the time of our inspection

there were two nurses taking calls. We were told that this increased to three nurses at the weekend. If necessary, medical staff could be called to the hub to assist with clinical decision making.

Managing anticipated risks

- There was a risk register in place that ensured potential risks were identified, assessed and appropriate control measures were implemented.
- There were robust local lone working procedures in the community to protect staff from harm. Each team had a folder, which contained information about staff including their car details. There was a prompt sheet for staff to follow if a member of the team phoned in and was in a dangerous situation. Staff visited patients in pairs if a safety risk had been identified and told us they felt safe knowing these procedures were in place.

Major incident awareness and training

- There were plans to deal with major incidents or events that would disrupt the delivery of care. Staff knew about the trust's major incident and continuity plan and where to access it on the intranet.
- We saw the Digital Care Hub business continuity plan which set out the steps to be taken in the event of failure of any part of the services.
- There were local business continuity plans in place for community services in the event of bad weather such as heavy rain, which may lead to roads being flooded. Staff had access to 4x4 vehicles which meant they could still reach patients' homes.

Good

Are services effective?

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

Summary

We rated the effectiveness of community adults services as good because;

- Community services worked with pathways based on National Institute of Clinical Excellence (NICE) guidelines and took part in local and national audit.
- We saw effective use of telemedicine. The digital care hub housed the intermediate care hub, the gold line service which provided care for patients in the last 12 months of their life, and the telemedicine service.
- Patient outcomes were measured at both local and service level. We saw examples of positive patient outcomes following intervention from community services.
- Staff appraisal rates were high at 89% and staff received regular supervision. Advanced Nurse Practitioners (ANPs) provided advice and support for staff caring for complex patients.
- We saw many examples of multidisciplinary and multi-agency working in order to provide effective care for patients. The Craven collaborative care team were a multi-professional team, which included mental health nurses and social care workers.
- Access to information was good. Patient records were held on the same electronic system used by the hospital and by most GP practices in the area. This allowed for sharing of information and good communication between health care staff. There was a plan to improve this further with agile working.

Detailed findings

Evidence based care and treatment

- Clinical nurse specialists were developing a relapse pathway for patients with Multiple Sclerosis (MS). The pathway was based on National Institute of Clinical Excellence (NICE) guidelines and NICE quality care standard QS108 which was published in January 2016.
- There was staff involvement in national audits, for example the cardiac rehabilitation nurses contributed to the National Institute for Cardiovascular Outcomes Research (NICOR) heart failure database. Community services also contributed to the National UK Parkinson's Audit and the National Cardiac Rehabilitation Audit.
- In 2015, community services had taken part in the Community Services and Community Hospitals benchmarking audit.
- We observed trust policies on the share point portal of the intranet and found that they were up to date.
- Staff could tell us about local audits they were involved in for example, hand hygiene audits and record keeping audits.
- Specialist nurses used social media to network with colleagues and to share articles and best practice nationally. They were also involved with local and national networks and had given presentations at regional conferences.

Pain relief

- Community nurses carried out pain risk assessments using a standard assessment tool.
- We observed a nurse carrying out a pain assessment using the assessment tool and documenting this in the patient's notes.
- We heard community staff discussing pain control with patients to ensure their pain was well managed and effective.

Nutrition and hydration

- A dietitian was in place to address malnutrition in the community. The dietitian's role was to educate staff around nutrition and hydration, working with specialist teams. Pathways had been developed for GPs to follow. One aim was to reduce the prescribing of supplements and encourage healthy diet choices and high calorie options. The impact of the role was being audited.
- We saw in patient records that community nursing teams used a nationally recognised risk assessment tool, the Malnutrition Universal Screening Tool (MUST) to assess patients at risk of malnutrition.

Good

Are services effective?

- We observed staff discussing nutrition and hydration with patients and this was documented in patient's notes.

Technology and telemedicine

- We visited the Digital Care Hub, which was based on Ward 15 within Airedale hospital. Within the hub, there were 23 screened workstations for nurses with room for future expansion. The hub housed several services, the intermediate care hub, the gold line service which provided care for patients in the last 12 months of their life, and the telemedicine service. The hub was located near to the general wards and the emergency department, which made it accessible to consultants and nursing staff and allowed more flexible working.
- The telemedicine service provided remote video consultations between Airedale staff and patients in their own homes, care homes and in prisons. There were separate rooms for private consultations and the telemedicine service for prisons nationwide. Clinical staff in the hub took calls from care home staff and were able to speak to residents directly whilst viewing them on the screen. Nurses used their clinical judgement to determine whether the resident needed to see a doctor or a community nurse or whether they needed to visit an emergency department. The aim was to support care home staff by providing clinical advice so that the most appropriate care could be accessed depending on the patient's needs. We observed several calls to the hub and saw that these were dealt with professionally and in a caring manner.
- We saw that some patients with heart failure had been supplied with an electronic tablet and could use this technology to contact the Clinical Specialist Nurse (CNS) for a face-to-face consultation. Patients were also able to take their own observations such as blood pressure and oxygen levels and discuss the results with the specialist nurse. This was an effective way of the patient receiving advice and reassurance on their condition and saved staff travel time as the geographical area covered by the specialist nurses was very large. Out of normal working hours, patients could contact the telemedicine service based at the digital care hub.

Patient outcomes

- Commissioning for Quality and Innovation (CQUIN) is a payment framework, which enables commissioners to reward excellence by linking a proportion of a provider's income to the achievement of local quality improvement goals. Community services for adults had six CQUINs in place, which included falls management and prevention, falls assessment, prevention and care planning, self-care planning, staff training re-self-care, personalised care and integrated discharge co-ordination.
- Senior managers told us that patient outcomes were measured at both individual and service level.
- Patients using cardiac rehabilitation services were able to choose which services they wanted to access. Patients had individualised care plans and set their own personal goals.
- The cardiac rehabilitation service used the Hospital Anxiety Depression Score (HADS) to measure improvement in patient outcomes. They also used the 'shuttle work test' to test patients at the beginning and end of their treatment program to measure an improvement in their condition. An audit showed that there were significant benefits for patients who completed the cardiac rehabilitation exercise classes with an increase in functional exercise capacity, and a decrease in anxiety and depression.
- Using telemedicine, patients in nursing and care homes were triaged prior to putting the call through to GPs to request a visit. The service could demonstrate that it had averted approximately 30% of calls from needing to go through to a GP.
- We saw a patient story written by a patient in prison who had received speech and language therapy via telemedicine. The patient had a severe stutter and said that having speech therapy was the best thing they had ever done and it had changed their life.
- Teams had specific key performance indicators to meet. We saw these displayed on notice boards in staff bases.

Competent staff

- The overall compliance rates for appraisals for community adults during the period October to December 2015 was high at 89%. Staff we spoke to had completed their appraisals with their line manager and said they found this useful.
- Therapy staff told us they received regular clinical supervision. Some support workers said they received supervision but it was quite informal.
- We saw examples of good skill mix in the collaborative care teams. The community support workers had generic skills based on the Calderdale competency

framework. This allowed them to undertake a wide range of delegated tasks therefore freeing uptime for qualified clinicians to concentrate on more specialist tasks.

- There were community specialist nurses in heart failure, cardiac rehabilitation, respiratory, parkinson's disease, neurology and lymphoedema who worked across both hospital and community settings. There were also specialist haemoglobinopathy and continence services available. Community nurses told us that there were able to tap into the specialist nurses expertise when they needed advice on a patient.
- Advanced Nurse Practitioners (ANPs) worked within the Craven virtual ward and the collaborative care teams. All ANPS were qualified nurse prescribers and supported staff caring for complex patients. They were a good resource for staff and provided training.
- We spoke with a nurse who was working in the telemedicine service and was undertaking a non-medical prescribing course. We were told that there were plans for more staff to undertake this qualification.
- In order to develop the community nursing teams, community services planned to have a practice teacher in place by September 2016. This meant that they would be able to start taking district nursing students. Managers were already conducting joint interviews with a university to find prospective students.
- Therapy teams told us they provided in-service training at team meetings. For example, training in respiratory competencies had recently been provided. This included testing the knowledge of staff following the training.
- Staff we spoke with said there were good opportunities for development. Nurses told us their line manager had supported them to complete their degree.
- Leadership development programmes were available for line managers. The trust ran a 'rising stars' and 'great line management' training programme. We spoke to managers who had completed the great line management programme.
- Community services supported student nurses on placement and received good feedback.

Multi-disciplinary working and coordinated care pathways

- There were two collaborative care teams; Airedale, Wharfedale and Craven. All teams were multi-disciplinary and included, occupational therapists, physiotherapists, registered nurses, mental health nurses and health care support workers. Advance Nurse Practitioners (ANPs) were also based with the teams.
- Social care assessors funded by North Yorkshire Council were based with the Craven collaborative care team in Skipton. Staff told us this worked very well as they held daily discussions on their patient's progress and future plans. Multi-disciplinary Team (MDT) meetings were held twice daily at 8.00am and 2.00pm. The Airedale and Wharfedale collaborative care team worked with social care assessors based in the hospital. They held MDT meetings twice a week.
- The community heart failure specialist nurses were based in a building on the main hospital site, which gave them good access to the wards and enabled them to work closely with staff on the medical wards.
- Community nurse specialists contributed to discussions at multidisciplinary team meetings at GP surgeries and on the hospital wards when required.
- Social care and healthcare staff worked together in the integrated intermediate care hub. The team had a good knowledge of all services available throughout the local area, including the voluntary sector. They aimed to find the best service to meet the patient needs.

Referral, transfer, discharge and transition

- The community nursing team told us that now they were seeing more patients with complex needs, many of them would need ongoing care and therefore would not be discharged from the service.
- The Collaborative Care Teams (CCTs) aim was to prevent unnecessary admissions and facilitate early discharge of patients from the hospital. They received referrals from a single point of access via the intermediate care hub based on Ward 15 at Airedale hospital. Referrals were received from GPs, community nurses, the community rehabilitation team, the hospice and from the hospital wards via the hub. Referrals were triaged and allocated to the appropriate team. The CCTs received approximately 100 referrals per month, and carried out approximately 2000 follow up visit per month.
- Clinical specialist nurses received referrals from a number of sources, which included GPs, consultants, and patients self-referring. Their visits and appointment were scheduled on the electronic booking system and they aimed to see patients within two weeks.

Good

Are services effective?

- The community therapy team triaged their referrals into urgent (seen within 2 days), soon (seen within 10 days) and routine (seen within 6 weeks).

Access to information

- The majority of community services held patient records in an electronic system. One therapy team we observed was still using paper based records and would soon be moving to electronic patient records as part of the plan to roll the system out to all community services.
- All GP practices in the area, with one exception, used the same system, which allowed patient records to be shared and enabled effective communication between primary care and community. Community staff were able to send and receive tasks from GPs and access test results using this system.
- The hospital was also in the process of moving onto the same electronic system, which would allow further information sharing and enhanced communication. Staff told us that information sharing was constantly improving.
- Community nurses told us that if their patients were admitted to hospital, they were able to see input from specialist nurses involved in their care, in the electronic patient record. They were also able to access discharge letters so they could anticipate patients' needs and know when they were returning home.
- Staff working in the telemedicine service were able to access patients' electronic records when providing a remote consultation with a patient.
- We were told that social services would soon be moving onto the same electronic system, which would further enhance joint working and communication.
- Staff told us that they did not have connectivity in patients' homes therefore they would make paper notes and complete the electronic notes when they returned to the office.
- The electronic patient record system had the facility to upload and store electronic photographs, which could be shared between professionals. For example, community nurses had access to digital cameras and could upload and share images of leg ulcers with the tissue viability nurses in order to discuss a treatment plan.
- There was a plan to roll out agile working to community staff from April 2016. Staff would be supplied with a tablet or laptop, which would allow them to access and input information onto patients' record at any location.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to had a good level of knowledge and understanding of consent, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). They could give examples of best interest meetings they had been involved in when patients lacked capacity to make decisions for themselves.
- We observed staff gaining verbal consent prior to providing care and saw that patient consent forms were appropriately completed. We also heard patients being asked for consent to share their electronic records with other professionals.
- Training compliance in the Mental Capacity Act was 91% for community services.

Good

Are services caring?

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

Summary

We rated community adult services as good for caring because:

- Patients we spoke with were happy with the care they received and told us staff were kind and supportive.
- We observed staff treating patients with dignity and respect. Teams had dignity champions whose role was to challenge poor care and promote dignity.
- Staff provided holistic care. There was a focus on promoting independence and enabling patients to manage their long term conditions.
- Emotional support was good. Mental health nurses worked in the collaborative care teams and could offer assessment and treatment to patients with mental health conditions.
- Specialist nurses were able to give emotional support to patients and their families. They referred patients to other organisations able to offer them further support.
- Friends and Family Test data for community services showed consistently high scores of between 95% and 100% for patients who would recommend the service to their friends and family.

Detailed findings

Compassionate care

- Staff talked to us about patient centred care and that they believed in putting patients first.
- We observed good interaction between staff and patients. We saw patients treated with compassion, dignity and respect. On one visit, we saw that the member of staff was not rushed and chatted with the patient not only about their treatment but also about the patient's day to day events.
- Patients we spoke with said all staff were very kind and supportive. One patient told us he was very impressed with community services and found them responsive and caring. He felt he could ask for help at any time and they would be there for him.
- We observed a holistic approach to patient care. There was a focus on promoting independence and enabling patients to manage their long term conditions. We observed a nurse supporting a patient to take their own blood sugar test.
- Teams had dedicated dignity champions whose role was to challenge poor care, educate, and inform staff working with them.
- We looked at Friends and Family Test data for community services for 2015. For all months, results were consistently good with services scoring between 95% and 100% for patients who would recommend the service to their friends and family. The most recent score we looked at was 96% for February 2016.

Understanding and involvement of patients and those close to them

- We visited 12 patients in their homes and observed good communication between staff and their patients. Staff gave clear explanations and checking patients understanding.
- We observed a nurse checking that a patient understood what they had discussed and asked if he had any questions. She was aware that she had given him a lot of information and did not want to overload him with this.
- Staff identified support options and discussed these with patients and their families before gaining consent and agreement.
- We observed community staff working closely with and supporting carers.
- One patient and relative told us that the service they received from the community nurses had been fantastic and they could not fault it.

Emotional support

- Staff told us they felt they had the time to spend with patients and provide the emotional support to meet their needs.
- Staff used motivational interviewing to encourage patients to self-care where this was appropriate.

Good

Are services caring?

- Mental health nurses worked in the collaborative care teams and could offer assessment and treatment to patients with mental health conditions.
- Specialist nurses were able to give emotional support to patient and their families. They also referred patients to other organisations able to offer support for example Parkinson's UK.

Good

Are services responsive to people's needs?

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

Summary

We rated community adult services as good for responsive because;

- There was close working with commissioners to provide services to meet the needs of the local population. We saw good examples of community services working closely and planning services with the acute hospital, and other agencies to provide integrated care to patients.
- We found some good examples of services responding to the needs of a diverse population. An interpreter was present at the cardiac rehabilitation exercise classes and there were women only hydrotherapy sessions available.
- We found services for community adults to be extremely accessible and timely. The telehealth service provided immediate access to expert opinion and diagnosis and was available 24 hours a day, seven days a week. Staffing at the hub was increased in the evenings, on weekends and bank holidays when demand was highest.
- The needs of vulnerable people were met. Mental health nurses were based in the collaborative care teams and could provide mental health support for patients. Teams had a dementia link person who attended the dementia focus group and shared information with the teams.
- Community services for adults received a low level of complaints and a high level of compliments. Staff told us they tried to deal with informal complaints as early as possible before they escalated.

However;

- Several members of staff told us they would communicate with a patient who could not speak English through a relative, which is not good practice.

Detailed findings

Planning and delivering services which meet people's needs

- We saw services for community adults were planned by close working and engagement with other organisations and local Clinical Commissioning Groups.
- The trust was part of the Airedale Partner's Enhanced Health in Care Homes Vanguard. This involved close working, planning and developing relationships with other organisations and neighbouring trusts.
- We saw evidence of services that were planned and delivered using a multiagency approach. Airedale Collaborative Care Team was a joint service provided by the trust in partnership with Bradford Metropolitan Council, Czjaka Care Group and Carers Resource with the support of local GPs in the Airedale and Wharfedale Clinical Commissioning Group.

Equality and diversity

- There was good compliance with equality and diversity awareness training. Staff in community services achieved 82% compliance, which exceeded the trust target of 80%.
- Staff were aware of cultural differences. They told us that patient information leaflets could be requested in different languages. We saw two heart failure information leaflets in Punjabi and Urdu. Staff could access interpreting services, which provided face-to-face interpreters in several languages.
- We saw signage in three different languages in some of the healthcare premises we visited.
- Community adult services were provided in some areas with a large population of people from black and minority ethnic (BME) communities. Staff told us about how they had tailored services to the needs of this population. For example, an interpreter was present at the cardiac rehabilitation exercise classes and there were women only hydrotherapy sessions available.
- Several members of staff told us that for routine contact with a patient who could not speak English, they would communicate through a relative. This is not regarded as good practice. However, they told us that for important issues they would ensure an interpreter was present. Speech and language therapists told us they always used a translation service, as the families did not always repeat what was said.

Good

Are services responsive to people's needs?

- Community nurses provided services to travelling communities in the Craven area.
- The trust had an inclusion champion award as part of its annual staff awards. A community speech and language therapist had recently won this award for their work with a patient with communication difficulties.

Meeting the needs of people in vulnerable circumstances

- Mental health nurses were based in the Collaborative Care Teams and could provide mental health support for patients.
- There was a dementia crisis prevention team in place who helped patients with dementia or memory problems avoid getting into an unnecessary crisis. The team was a partnership between Airedale NHS Foundation Trust, Bradford District Care Trust and the Alzheimer's Society. The team included community mental health nurses, community nurses, occupational therapists, dementia support workers and community support workers covering Airedale, Wharfedale and Craven.
- Staff told us that they had received dementia training. They had attended an education and awareness session and found it useful in understanding the needs of patients with dementia. Teams had a dementia link person who attended the dementia focus group and shared information with their teams.
- A health care support worker told us about the 'mini mental test' they use for screening patients for signs of dementia. If they had any concerns, they would pass the patient's details on the mental health nurse in the team.

Access to the right care at the right time

- The collaborative care teams provided a 24 hour service, 365 days a year. They supported patients for approximately six weeks until a care package was in place. Staff told us that demand for the service fluctuated however when they were fully staffed they could be very responsive and could see patients quickly. Capacity and demand data collected from September 2015 to December 2015 showed that the Airedale collaborative care team had capacity to meet demand 94% of the time during this period whilst the Craven collaborative care team had capacity to meet demand for approximately 65% of the time. If a team was under pressure to meet demand they would follow the escalation plan and contact other teams for help.
- The collaborative care teams supported patients who were referred on the deep vein thrombosis (DVT) and cellulitis pathways, allowing patients to receive care at home and only go to hospital for certain tests. This meant these patients would not need admitting to hospital as they could have their care at home.
- The community nursing teams delivered services from 8.00am to 9.00pm, seven days a week. The collaborative care teams provided evening and night cover. This meant there was nursing care available 24 hours, seven days a week.
- The telehealth service provided immediate access to expert opinion and diagnosis and was available 24 hours a day, seven days a week. We were told that staffing at the hub was increased in the evenings, on weekends and bank holidays, as this was when demand was highest.
- Patients could contact the heart failure nurses between the hours of 7.30am to 6.30pm. Outside of these hours patient calls would automatically be put through to the digital care hub and they would be able to speak to a qualified nurse for advice and reassurance.
- The intermediate care hub was based at the digital care hub. The service provided a single point of access for GPs, nursing staff and other health professionals referring patients with intermediate care needs. Social care and health care staff, who had an overview of capacity across the region, staffed the service. They assessed the needs of the patient and arranged short-term hospital beds, respite care or services to support patients to stay in their own homes. They aimed to provide a responsive service, which ensured each patient received the right kind of support when they needed it and prevent unnecessary hospital admissions.
- A service level agreement was in place with agreed criteria for the intermediate care hub to triage referrals. This was within one hour for the urgent one hour pathway, two hours for other urgent referrals, the same day for non-urgent and the next day for routine referrals. Compliance was not routinely reported.
- There were plans to develop and extend the intermediate care hub to receive all referrals for integrated community services in 2016.

Learning from complaints and concerns

- Community services for adults received 16 complaints between March 2015 and November 2015. Of these,

three were formal complaints and 13 were issues raised with the Patient Advice and Liaison Service (PALS). The service also received 539 compliments, collected on the back of Friends and Family questionnaires.

- There was a process for formal complaints. The complaint would first go to the Chief Executive, then be sent to the Head of Community Services or the Head of Therapy Services who would appoint a lead investigator to undertake the investigation and formulate a response.
- Staff told us that informal complaints were dealt with as early as possible before they escalated. The member of staff dealing with the complaint then shared this with their team to ensure there was shared learning.
- The team leader for the collaborative care team was not aware that any formal complaints had been made about the service.
- We saw that complaints were discussed at team meetings, giving an opportunity for staff to reflect and learn from them.
- Community specialist nurses carried leaflets for the Patient Advice and Liaison Service (PALS) and gave them to patients if they wished to make a compliant or had a concern.

Outstanding ☆

Are services well-led?

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

Summary

We rated community adult services as outstanding for well led because:

- Senior managers shaped their services to meet the overall trust vision of 'Right Care'. Services were being developed and transformed to ensure that patients received care closer to home.
- Clear governance arrangements were in place with risks assessed, documented and control measures implemented. Community services produced a monthly quality account dashboard, which showed performance against patient safety, clinical effectiveness and patient experience indicators.
- We found strong leadership at local and senior level. Staff spoke highly of their managers and told us they often saw them and they were approachable. Managers told us they were extremely proud of their staff.
- There was patient involvement in focus groups to develop new pathways of care and the services participated in the Friends and Family Test.
- Staff were highly engaged. They enjoyed their work and were patient centred in their approach. They told us they felt valued, supported and well managed.
- We found a culture of continual service improvement and innovation. There was an understanding and willingness to embrace new ways of working.

Detailed findings

Service vision and strategy

- Staff and managers we spoke to were aware of the trust values and vision. Staff said they had mandatory training on the 'Right Care' vision.
- Senior managers for community services shaped their services to meet the overall trust vision of 'Right Care'. Services were being developed and transformed to ensure that patients received care closer to home or received support to care for themselves.
- We saw the integrated care group annual plan for 2016-2017, which set out the direction for community services for 2016-2017. There was also plan for therapy services.
- We spoke to a member of staff who was a 'right care' champion. Part of this role was to take part in initiatives to boost awareness of the trusts right care vision and work programmes.

Governance, risk management and quality measurement

- There were risk registers in place for community services to ensure potential risks were identified, assessed and appropriate control measures were implemented. Highest risks were escalated onto the integrated care directorate risk register.
- Senior managers for community services were aware of their top three risks and had plans in place to mitigate or reduce these risks. We saw these clearly documented on the risk register and found they were consistent with issues we identified during the course of the inspection.
- Community managers regularly attended community quality and safety meetings, which fed information up into the medical governance meeting.
- Community services produced a monthly quality account dashboard, which showed performance against patient safety, clinical effectiveness and patient experience indicators. This was discussed at the monthly community service business meeting, which was chaired by the head of community services. The dashboard was benchmarked against last year's performance.
- Business and quality meetings were underpinned by regular service and team meetings.
- Senior managers for community services for adults attended the monthly Deliverance Assurance Group (DAG) meetings, which fed into the Executive Assurance Group. Risks were escalated through the DAG.

Leadership of this service

Outstanding ☆

Are services well-led?

- Senior managers told us what they were most proud of was their staff. They said in light of the introduction of new ways of working, staff had been resilient, committed to each other and to their patient's needs.
- Staff told us that they felt well supported and valued by their managers. Community nursing teams said their team leaders were excellent and they spoke highly of the senior managers for community services.
- Staff said that managers were open to new ideas and encouraged them to be innovative in order to develop services for patients.
- Local managers said they felt well supported and valued.
- Team leaders had implemented measures to support the development of resilience within community nursing teams. This involved coaching and involvement of the employee health and wellbeing team.
- Managers had put good systems in place to keep staff safe. For example, there were local lone working procedures in community nursing. There was a procedure to follow for staff who found themselves in a situation where they felt unsafe. All staff we spoke to knew about this procedure and knew how to react if a colleague was in danger.
- Staff said they often saw senior managers and they were approachable. Both the Director of Nursing and the Chief Executive had visited teams and shadowed staff on visits to patients.
- Staff sickness was actively managed using an agreed process. Sickness rates for community services were below the trust average.
- Advanced Nurse Practitioners (ANPs) provided good clinical leadership. They worked across all teams and offered advice and support on clinical issues to staff.

Culture within this service

- We found a positive staff culture in community services. Staff enjoyed their work and were patient centred in their approach.
- Community nursing staff told us they felt proud of what they achieved for their patients and appreciated. They believed they really made a difference to patients. Two support workers told us about a patient who had a large wound which had taken three years to heal. Once it healed, the patient was able to go out again. They felt they had changed her life for the better by providing care.
- Teams were well established with many staff working in the area a number of years in both the acute hospital and community. Staff knew each other well and there were good relationships across teams.
- There was an understanding and willingness to embrace new ways of working. Multi-professional teams worked across acute and community settings and with other agencies to improve patient care.

Public engagement

- Patients were involved in focus groups to develop pathways of care. The Head of Therapy Services told us about a working group which was in place to look at a service redesign to support the early discharge of stroke patients. Carers and staff were involved in the project, which carefully considered the carer's point of view. A business plan was in place to support the project.
- There was a patient experience lead for the trust who was able to support community teams with patient engagement initiatives.
- Teams such as the collaborative care team and the pulmonary rehabilitation team carried out quarterly patient satisfaction surveys. The results were used to improve services further.
- The trust used patient stories to learn from and improve services. We saw that patient stories were discussed in the minutes of team meetings and at board meetings.
- The service participated in the Friends and Family Test.

Staff engagement

- The staff friends and family test results for quarter two 2015/16 showed 85% of staff were likely or extremely likely to recommend the trust for care and treatment compared to the national average of 79%. Seventy five percent of staff were likely or extremely likely to recommend the trust as a place to work compared to a national average of 62%.
- We found that morale was generally high amongst community staff. Staff told us they felt valued, supported and well managed.
- Staff we spoke to were proud of their teams and said they worked closely together and had good communication and support.
- Staff in community services told us that they felt integrated with the acute services in the trust, and did not feel isolated. They said there was ongoing dialogue with the hospital teams, they felt connected and involved.

Outstanding ☆

Are services well-led?

- Staff told us they felt listened to. Some teams had complained that during winter pressures when it was extremely busy, they did not have time to eat and drink, and often went without lunch. In response to this, over the winter teams had received food and drink packs delivered to their office.
- The 'Pride of Airedale' awards were in their second year and recognised staff who went the extra mile and were nominated by their peers for providing outstanding care. The Lymphoedema team had recently won the best customer service award.
- Sickness levels for December 2015 and January 2016 were low for community services at 2.1% and 2.9% respectively. This was below the trust target of 3.6%. We looked at sickness levels in the previous eight months from April to November 2015, which were higher and ranged between 4.7% and 7.3%.

Innovation, improvement and sustainability

- We found a culture of continual service improvement and innovation in adult community services. There were several examples of enhanced integration between health and social care within community services for adults.
- The trust were part of the Airedale Partner's Enhanced Health in Care Homes Vanguard whose objective was to enhance the quality of life, and end of life experience for thousands of nursing and care home residents living in Bradford, Airedale, Wharfedale, Craven and East Lancashire. By using enabling technologies, such as telemedicine and the intermediate care hub, nursing and care home residents and their carers benefitted from being able to access expert advice and support remotely 24 hours a day, 7 days a week. The Vanguard programme, aimed to go further and develop a more proactive health and social care enabling model focusing on optimising residents individual capabilities and building new clinical models of care.