Care Quality Commission

Harrogate and District NHS Foundation Trust

RCD

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RCD01	Harrogate District Hospital	End of Life Care	HG2 7SX

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

Summary of findings

Ratings

Overall rating for the service	Outstanding ☆
Are services safe?	**Good** 🟢
Are services effective?	**Good** 🟢
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** 🟢
Are services well-led?	**Outstanding** ☆

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Overall summary

Overall, we rated adult community health services as good for safe, effective and responsive and outstanding for caring and well led.

We rated safe as good because the teams were collating safety performance data and most of the time this was better than the national average. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Managers shared the learning from incidents across teams. All staff took a proactive approach to safeguarding. Mandatory training across all services was above the trust targets. Medicines were stored securely in and staff administered these in line with the trusts policies. Staff handovers were effective and patient care records were completed to a high standard. We found that people were protected from avoidable harm and abuse. The trust had robust systems in place for managing risks including major incident planning. Access to equipment in people's homes was good and the trust had robust systems in place for the delivery and collection of equipment. However, we also found that some medical devices were out of date for servicing and maintenance. There was limited evidence of environmental and hand hygiene compliance audit. Managers and staff members in community nursing and therapies teams told us that staffing was an issue. Staff told us that they often work more than their contracted hours due to demands on the service. Gaps in staffing were filled but this was mainly by substantive members of staff working bank shifts that might not be sustainable in the long term.

We rated effective as good because people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. A centrally hosted clinical computer system allowed most staff to access and share records. Patients were receiving advice about pain relief. There was participation in relevant local and national audits. Staff received timely appraisals and were supported with professional development. There was evidence of multi-disciplinary working across all teams and evidence of collaborative working with the local authority. Referral processes were straightforward and staff did not raise any concerns about these. Consent to care and treatment was obtained in line with legislation and guidance,

including the Mental Capacity Act 2005. We saw evidence that patients were supported to make decisions. However, we also found that although most staff had access to information via the trust intranet, staff at remote sites told us, at times, they felt isolated, experienced difficulties and frustrations in relation to the IT systems. Staff told us that not having mobile working devices caused them duplication in work and created a significant amount of non-effective work time. We also found that not all care pathways reflected references to nationally recognised best practice.

We rated caring as outstanding because feedback we received from patients was consistently positive about the way nursing and therapy staff treated them. Patients told us that staff go the extra mile and we witnessed this during our inspection. We observed a number of staff and patient or carer interactions during our inspection. This included fifteen home visits and six observations during clinic appointments. We observed consistently caring and compassionate staff. We received 174 comment cards during our inspection, these also consistently contained positive comments about the community adult services, in particular about the podiatry services. Staff were highly motivated and inspired to offer care that is kind, promotes people's dignity, and involved them in planning their care. Patients said that staff were 'wonderful' and 'amazing'. We saw staff providing detailed explanations of procedures, thorough assessment of all needs and reassurance. Relationships between patients, those close to them and staff were strong, caring and supportive. Patients were supported emotionally. All staff were responsive to the psychological needs of patients.

We rated responsive as good because services were planned and delivered in a way that meets the needs of the local population. The needs of different people were taken into account when planning and delivering services. Staff respected the equality and diversity of patients and their families. The facilities and premises were appropriate for the services being delivered. We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia, a cancer diagnosis and learning disabilities. The community nursing and therapies team provided a seven day, twenty-four hour service. The community

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equipment store had moved from a five to a six-day service and staff we spoke to told us that they would be keen to extend this further. Podiatry services were provided across the region. There were low numbers of complaints. We spoke with senior staff and found that there was an openness and transparency in how complaints were dealt with. Complaints and concerns were taken seriously and responded to in a timely way. We saw evidence of improvements made to the quality of care as a result of complaints and concerns.

We rated well led as outstanding because the trust had a clear statement of vision and values which was integrated within the teams. Staff we spoke to were aware of and based their care around the trusts values. Senior staff shared details of the board and governance meetings with staff. Staff within the community service teams were aware of their risks and could explain these including any work that was being undertaken or that had been

completed in order to mitigate their risks. Senior staff were visible and supportive to staff and patients. The majority of staff in the service told us that senior staff for the trust were also engaged with the services provided in the community. All staff we spoke with said that senior staff were very approachable. One said they had a 'fantastic supportive team, I love my job. I feel very well led and have never been happier'. We witnessed the culture within teams as being team focused and positive. All staff we spoke with told us that they worked as part of a team and felt supported within their service. We saw good examples of public engagement within most teams. Staff were proud of the teams they worked in and told us about innovation they had been involved in. There was a strong focus on continuous learning and improvement at all staff levels. Staff shared innovations and improvement work that they were involved in.

Summary of findings

Background to the service

The adult community health services covered all services provided to adults in their homes or in community-based settings. The services were mainly focused on providing planned care, rehabilitation following illness or injury, ongoing and intensive management of long-term conditions, coordination and management of care for people with multiple or complex needs and acute care delivered in people's homes and health promotion.

The services provided by Harrogate and District Foundation Trust included community nursing services, integrated care teams, including district nursing, community matrons and specialist nursing services, community therapy services, community intermediate care, community rehabilitation services and community outpatient and diagnostic services.

The trust provided community services at one hundred and thirty seven locations.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Independent Chair

Head of Inspection: Julie Walton, Care Quality Commission

Team Leader: Karen Knapton, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a community matron.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation

and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 2 to 5 February 2016.

During our inspection, we spoke with fifty-two members of staff of all disciplines and grades. We also attended two staff handovers involving thirteen staff.

We visited staff bases and spoke to an operational manager, team leaders, the matron, community nurses, district nurses, care support workers, physiotherapists, occupational therapists, community matrons, tissue viability nurses, therapy assistants and administrators.

Summary of findings

We travelled to community clinics and saw wheelchair services, podiatry, speech and language therapists and their assistants. We also spoke to the community infection control team.

We looked at fifteen paper and electronic care records and spoke with twenty-one patients and ten relatives/carers. We accompanied staff on fifteen home visits and saw staff providing care and treatment in patients' homes and looked at the paper based care records in the home environment.

We went to two community equipment stores and spoke to staff in these locations. We looked at the electronic processes in place for the ordering and delivery of equipment and how this and all other community health services were managed across the rural location of Harrogate and District foundation trust.

What people who use the provider say

Feedback we received from patients, about community services, was consistently positive. Patients told us that staff go the extra mile and that they value the services provided. Patients described staff as 'wonderful' and 'amazing'.

The CQC comments card feedback from people was very positive.

Areas for improvement

Action the provider MUST or SHOULD take to improve
The trust must

- Develop a robust infection prevention and control audit programme for environments and hand hygiene.

- Ensure all community medical devices are subject to servicing and maintenance in line with recommended guidelines

The trust should

- Ensure that all care pathways reflect and reference evidence based best practice guidance for staff.

- Ensure staff have appropriate technology to reduce non effective work time and excess hours for community staff

- Look at improving access to IT systems in remote bases

CareQuality Commission

Harrogate and District 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 safe as good because:

- The teams were collating safety thermometer performance data and most of the time this was better than the national average.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Managers shared the learning from incidents across teams. All staff we spoke with were aware of their responsibilities and took a proactive approach to safeguarding. Mandatory training across all services was above the trust targets.
- Medicines were stored securely in and staff administered these in line with the trusts policies.
- We saw effective staff handovers and patient care records were completed to a high standard.
- We found that people were protected from avoidable harm and abuse. The trust had robust systems in place for managing risks including major incident planning.

Some teams had recently been involved in adverse weather with many areas flooding. Staff told us that they had managed to maintain the services for patients during this time.

- Access to equipment in people's homes was good and the trust had robust systems in place for the delivery and collection of equipment.

However we also found that:

- Some high-risk items of equipment were out of date for servicing and maintenance.
- Although we observed good practical compliance, there was no evidence of effective environmental and hand hygiene compliance due to there being no robust audits undertaken.
- Managers and staff members in community nursing and therapies teams told us that staffing was an issue. Staff told us that they often work more than their contracted hours due to demands on the service. Gaps in staffing were filled but this was predominantly by substantive

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members of staff working bank shifts, which might not have been sustainable in the long term. We also saw that staffing shortages had been cited as a root cause when a patient had developed a pressure ulcer.

Detailed findings

Safety performance

- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.
- The NHS Safety Thermometer, an element of CQUIN, is an audit tool that allows organisations to measure and report patient harm in four key areas (pressure ulcers, urine infection in patients with catheters, falls and venous thromboembolism (VTE)) and the proportion of patients who are "harm free". The 2014/2015 CQUIN scheme rewarded submission of data generated from use of the NHS Safety Thermometer. The England average for harm free care is 95%.
- We saw ninety-six safety thermometer data collections from eight community teams between February 2015 and January 2016. Harm free care was consistently above 95% in most teams each month. We saw that in five teams harm free care dropped below 95% on twelve occasions. The lowest being 87% in one team in November 2015.
- We spoke to staff from community nursing teams and they were aware of the safety thermometer. We saw this information displayed at the community-nursing base that we visited.
- Senior staff told us that safety thermometer data was also communicated via the team brief that was e-mailed to all staff. We also saw that the safety thermometer data discussed in team meeting minutes.

Incident reporting, learning and improvement

- The trust used a recognised electronic reporting system. All staff we spoke with told us that they used the system.
- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There had been no reported never events for this service.

- Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services provided to patients. Serious incidents should be reported on the Strategic Executive Information System (STEIS) within two working days and reported to the National Reporting and Learning System (NRLS) or regulator as appropriate.
- In 2015, the trust reported thirty-six serious incidents on STEIS for this core service. These were all pressure ulcers of grade 3 or above.
- Between December 2014 and November 2015 the trust reported 128 incidents on NRLS for community services however, these figures included primary care and therefore it was not possible to establish the exact numbers for this core service. However, the majority of these 96% (123) were reported as low or no harm.
- We looked at three root cause analysis (RCA) completed within the core service and found that these were comprehensive investigations which highlighted root causes and learning. We also saw completed action plans and evidence of shared learning for these.
- We saw that one RCA identified staff shortages as a root cause in one incident where a patient had developed a pressure ulcer.
- In November 2014, the duty of candour statutory requirement was introduced and applied to all NHSTrusts. The trust had a policy in place relating to the new requirement and provided evidence of communication with staff in the form of a staff bulletin in August 2015 and they had also used the intranet screen saver to promote the requirements.
- The trust has informed staff about the duty of candour via and information leaflet and the intranet that there was a trigger on the electronic reporting system. The trust told us that this regulation was also now included in the induction programme for staff.
- All staff we spoke with about this were aware of Duty of Candour and could give examples of when this had been or would be used. We saw evidence that the duty of candour was included as part of the RCA process.
- The leads for community nursing teams told us that they shared incident details and feedback at quality care meetings and team meetings. Staff we spoke with confirmed this and we saw evidence of this in team meeting minutes and bulletins provided for staff.
- We saw a copy of the Podiatry Quality Matters (January 2016). We were told by senior staff that this was

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communicated to all staff in the podiatry teams and staff we spoke with confirmed this. This showed details of recent incidents and also two gave examples of root cause analysis and the learning from these.

- We understood that there were concerns within the podiatry teams around the disposable blades from scalpels not being removed prior to the handles being sent for decontamination. We saw that these incidents were being reported on the electronic reporting system. Senior staff were monitoring this concern and the quality matters briefing paper included staff updates each month.

Safeguarding

- The trust lead for safeguarding was the chief nurse. There was also a designated safeguarding doctor and nurse.
- Staff told us that they completed safeguarding training as part of statutory mandatory training. Overall trust compliance with level 1 adults safeguarding training was 85% against a target of 75 -95%. Data provided by the trust showed that 87-89% of community staff had completed safeguarding training.
- All staff we spoke with about training told us that they had completed safeguarding training and were able to describe the process they would follow if they had a concern or needed to raise an alert. One member of the therapies team gave us an example of a safeguarding concern that they had been involved with.
- Staff also said that they knew how to access safeguarding policies and procedures via the trust intranet and we saw this in practice.
- Staff also said that the trust held link nurse meetings and the electronic reporting system linked to safeguarding.
- Senior staff told us that that they attended safeguarding strategy meetings and that the safeguarding lead was very supportive.
- We saw safeguarding on the agenda of some team meetings within the services including podiatry, community nursing and therapy teams.
- During our inspection, we observed a newly qualified member of staff completing a safeguarding referral after discovering a patient had developed unstageable pressure ulcers in a care home.

Medicines

- Access to medications, in particular controlled drugs for use in patients' homes, had been on the community services risk register because not all local pharmacies kept these drugs as stock items. The matron told us that they had worked with the commissioners and local chemists to resolve this risk and that they now had a cohort of chemists that stocked the required medications.
- Staff we spoke with knew about this risk and how this had been mitigated.
- Community nurses did not carry any medications however we witnessed community nursing staff administering medications for example insulin and anticoagulants and found that these were appropriately prescribed on a medication administration record (MAR). We observed staff checking the MAR before administering medications.
- Staff were able to administer some medications via patient group directions for example for influenza vaccines and antibiotics in line with best practice for patients having catheters inserted. We saw that these were in date and signed appropriately.
- We saw that when dressings were prescribed, for example for community nursing staff to use on patients wounds, these were documented in the patients electronic care record.
- Podiatrists gave local anaesthesia via their local anaesthesia certificate (LAC) which was part of their initial degree qualification. Podiatrists required annual updates for this. A senior podiatrist told us that the trust monitored staffs annual update.
- Staff in podiatry told us that if they felt a patient needed any additional medications for example antibiotics for infection they would liaise with the patient's own G.P.

Environment and equipment

- The trust provided services at one hundred and thirty seven locations. During our inspection, we visited four community team bases, five clinics and two equipment stores. We found that some clinic and service bases were dated and in need of updating however not, all of these areas were the responsibility of the trust.
- Services were planned so that they were convenient for the people who needed to access them.
- We found that all clinic rooms where patients where patients were treated were visibly clean. However, in

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one location we found that the cleaning log was not completed prior to the clinic starting, which meant that there was no evidence that the equipment was clean prior to it being used for patients.

- We looked at equipment used in clinic settings and found that most items of equipment had servicing stickers. We spoke to staff about the items that did not have stickers and were told that this was because the equipment was less than a year old.
- We saw a blood and body fluids spillage kit available in one clinic. This was sealed but did not have an expiry date. We brought this to the attention of the member of staff working in the clinic.
- During a home visit, we saw new equipment being delivered and staff showing a patient's carer how to use it. The member of staff told us that an occupational therapist might be involved for complex equipment.
- One community nurse we spoke with told us that training was provided for the use of equipment, for example for syringe pumps.
- We visited two community equipment stores during our inspection. We looked at the environment and processes for managing the availability of equipment for delivery to patients' homes. We found that the trust had robust processes for the management of equipment.
- Staff working in the equipment store told us that they managed 100,000 items of equipment each year and had a key performance indicator (KPI) target of 95% for equipment delivery within timescales. On average compliance was higher than the target at between 97 and 98%.
- Data provided by the trust showed that between April 2015 and September 2015 the team had delivered urgent (next day) and priority (within six hours) orders within the timescales 100% of the time. Standard orders (within 7 days) were also consistently above the 95% KPI and were usually delivered within three to six days.
- We saw that all equipment was labelled with a unique identifier and also showed contact details for the equipment store.
- Servicing and maintenance of equipment provided by the equipment store in to patients' homes was completed in line with manufacturers recommendations. Some of this, for complex or electronic equipment for example patient hoists, was provided via service level agreements with external companies.

- All staff we spoke to about equipment told us that access to equipment both in and out of hours was very good.
- Staff in wheelchair services told us that repairs to wheelchairs were being delayed due to the repair service being lost to a private sector company and because of financial constraints.Data provided by the trust showed that 99.2% of repairs (against a target of 95%) were completed on time. Staff at one centre told us that a patient transfer hoist had been reported as being due an annual service maintenance test several months ago and they were still awaiting validation.
- Data provided by the trust showed that 865 medical devices were in date for service however 188 (22%) were out of date. This included twenty-six high-risk items, one of which was a defibrillator in a remote clinic which was last serviced in March 2014.

- The trust also provided data showing that all domestic electrical appliances in staff bases had been tested for electrical safety in line with recommendations.

Quality of records

- During our inspection, we looked at fifteen electronic and paper care records of patients being cared for by various staff in community services including nurses, occupational and physiotherapists and podiatrists.
- We found that records were completed fully and consistently across all services. We saw comprehensive assessments of patients needs and care plans in place to manage the risks. This meant that records were in line with staffs registering bodies.
- We also saw paper records in patients home and found that these were consistent with the information that had been logged on the electronic system.
- Where relevant we saw additional information in care records, for example wound photography which meant that staff could monitor patients' progress and also share information with other services, for example the tissue viability nurses.
- We saw an audit tool for community nursing and therapy records that was due to be piloted. There were no previous record audits available for these staff.
- We saw an audit that had been completed for podiatry records. This showed varying compliance in relation to the completion of the records, however it was established that some of these results were due to there being some confusion about which clinician is

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responsible for the completing the shared record, for example if this should be the patients general practitioner or any other clinician seeing the patient. An action plan had been developed following the audit being published however because this was a recent audit the deadlines for completion were all following our inspection.

Cleanliness, infection prevention and control (IPC) and hygiene

- Staff completed IPC training as part of their statutory mandatory training. Information provided by the trust showed that compliance for teams within this core service was between 87% and 100%.
- We visited and spoke with staff from the community IPC team. We were told that they did not have an environmental audit schedule for community sites but that audits were completed on an ad hoc basis and that unannounced visits also took place.
- We asked the trust to provide details of any IPC audits that had been completed. We only received details about one audit which had taken place at one of the community equipment stores. This was a pre CQC visit audit. The feedback from this was provided as an emailed list of non-compliance and actions to be taken.
- We were told by the trust that the community IPC team had recently prioritised environmental audits for dental services in the community. However we were also told that the team had plans in place to audit podiatry and dental services annually, and there is now an on-going requirement for all community teams to undertake and submit relevant Saving Lives audits.
- We accompanied community nursing staff on visits to patients' homes and found that appropriate personal protective equipment (PPE) was used; we only saw one occasion when a nurse did not use an apron when it would have been appropriate to do so.
- We observed community staff performing hand hygiene and adhering to bare below the elbow.
- We asked to see audits for hand hygiene for community nurses and were told that these were due to be reinstated. We saw a copy of an action plan to address this deficit. We did however see one audit that was completed in January that showed 100% compliance in the rapid response team.
- We saw community nursing staff disposing of sharps for example needles in line with recommendations.

- We saw appropriate cleaning and decontamination of equipment that was returned to the community equipment stores. Staff told us that the infection control team perform audits of the sites and the IPC team we met with told us that they had assessed the decontamination processes at the equipment stores and found these to be compliant with relevant guidelines.
- One member of staff at a community equipment store told us that the occupational health department monitor the staffs' immunisation status, for example for hepatitis B and ensure that these were kept up to date.
- A podiatry patient told us that staff were 'always washing their hands' and that they wear gloves.
- We noted that in one clinic a dressing trolley was not routinely cleaned between patients. We asked about this and were told that the equipment cleaning and the log sheet for this was completed at the beginning and the end of each clinic. However on checking the log there was nothing documented to indicate that the equipment had been cleaned at the start of the clinic that day.
- We also saw the Preventing Healthcare Associated Infection Aseptic and Clean Technique for Podiatrists document which stated that Clinic Preparation should include the following:
  - Thoroughly clean all "touched" surfaces, e.g. dressing trolley, cupboard handles, work surfaces, examination light, telephone etc.
  - Use detergent wipes if surfaces are visibly dirty, alcohol wipes if not.
  - Clean patient and clinicians chair with detergent wipes. Alcohol wipes may have a detrimental effect on the vinyl over a period of time.
- We looked at the standard operating procedure (SOP) for podiatry that stated that cleaning wipes should be used to wipe down the podiatry couch and leg rests between each patient.
- This meant that on this occasion the member of staff had failed to adhere to either of the above guidelines.
- Podiatrists used non-disposable instruments these were sent to a central sterilisation unit. Staff completed tracking sheets using patients NHS numbers to ensure traceability.
- The risk of injury to staff due to blades being left on instruments when returned to sterile services was highlighted on the risk register for podiatry. We saw that this risk was discussed in team meetings and also

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documented in the podiatry quality matters briefing paper in January 2016. Staff we spoke with were aware of the risk and we saw that this was being monitored each month by senior staff. We also saw that an SOP to minimise this risk had been developed.

Mandatory training

- There was a trust mandatory training policy in place which referenced 30 statutory training requirements, mandatory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act, deprivation of liberty safeguards (DoLS) and others.
- For each training element staff groups were identified and the frequency of each training element. Employees had a "Personal training account" which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- Compliance with training was managed through a RAG (red, amber green) rated system for the individual through to directorate and trust level.
- The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or above – this was explained as the trust identifying that they would have been on track to meet trajectory. Figures below 75% were rated as red or amber dependent on the percentage.
- Across all community services the compliance rate was between 77% and 100%. This meant that staff in community services were meeting the trusts targets in relation to all statutory mandatory training.
- When we asked staff about their training most told us that they were up to date.
- Within the podiatry teams, an administrator monitored staffs mandatory training and contacted them via e-mail when they needed to update any training. We saw an example of this, a staff member had received an update advising them which modules they needed to complete by the end of February 2016.

Assessing and responding to patient risk

- Advice is issued to the NHS as and when issues arise, via the Central Alerting System. National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare

system to risks and provide guidance on preventing potential incidents that may lead to harm or death. We saw details of NPSA alerts displayed in community nurse and therapy team bases.
- We saw pressure risk assessments completed in all of the electronic records we looked at. We saw community nurses reassessing patients at risk during home visits.
- We also saw other patient risk assessments completed in care records including falls, malnutrition, and mobility.
- Staff in community nursing teams told us that they could refer patients to the tissue viability nurses if they needed support with wound care. Staff said that they photograph wounds and these were uploaded onto the patients electronic care record so that they can be reviewed and reassessed by different staff.
- Staff working in community teams did not use a deteriorating patient recognition tool because this initiative was not routinely a tool that was applicable to their services however, managers we spoke with told us that they were benchmarking with other areas who had introduced a tool that was being used for the assessment of patients in their own home.
- We observed two staff handovers during our inspection. One for a rapid response team and one for a community nursing team. Both handovers were well attended by all relevant staff and it was apparent that all staff had a good understanding of the patients. We observed a comprehensive patient report for all patients on the teams caseload. Staff discussed pertinent issues relating to individual patient risk and talked about the need for specialist input where required for example tissue viability or continence nurse involvement. We heard staff speaking in a caring and compassionate manner about all patients. We also saw that patient home visits were allocated based on staff skill mix and patient need. Where appropriate evidence based care and treatment was discussed.
- A member of staff at a community equipment store told us that they do occasionally need to respond to patient risk for example if a driver found a patient on the floor or could not gain access to a property they would call 999.

Staffing levels and caseload

- Information provided by the trust indicated that there were 20.84 (7.3%) whole time equivalent (WTE) vacancies across all adult community service teams.

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- The highest levels of vacancies were in community equipment stores which had 5.34 wte vacancies (20%), community nursing which had 5 wte vacancies (8%) and the community fast response team with 2.48 (nearly 6%) vacancy.
- Managers we spoke with told us that staffing was a concern and the average caseload per member of staff or team was not known. However, they were looking at patient demographics, team boundaries and trying to allocate patients according to postcodes.
- Senior staff in community nursing told us that they do use bank staff however; most of these staff had substantive contracts within the team.
- Almost all staff we spoke to in community nursing and therapy teams told us that staffing was an issue. Staff reported that they frequently worked over their hours to meet the needs of the service. Managers confirmed this and told us that it was on their 'worry list'.
- Recruitment was seen as a problem and senior staff were looking at flexible options for example to invite newly qualified staff in to the team and upskill them so that they can become valuable members of the team.
- We observed a team handover at a community and therapy base and saw that staff allocation and skill mix was agreed for each shift.
- We were told that caseload allocation was based on units. Each unit was fifteen minutes and staff were usually allocated 20 units per day. Each day staffs travel, completion of referrals etc. and entering data on to the patients' electronic record were additional to the units or visits allocated.
- We saw evidence that staff shortages had been cited as the root cause of pressure ulcer development. One member of staff we spoke with told us that she had submitted an electronic incident report after being allocated thirty-eight units in one day. This was reported because the staff member was concerned that they were unable to complete patient assessments appropriately.
- We spoke to one community nurse who told us that she had been allocated nineteen visits that day.

Managing anticipated risks

- Many staff in community services in particular those visiting patients home often do so alone. Therefore, they are more vulnerable to attack and assaults, more exposed to hazards and more likely to be injured.

- The trust had lone working guidelines and staff completed an online e learning module.
- In addition to this, we saw a copy of the trusts Integrated Care Directorate Business Impact Analysis dated November 2014. Which was a comprehensive business continuity plan covering all community services.
- Community staff worked in isolation until 22:00. After this time, two staff worked together on home visits.
- Community health services undertake a range of environmental risk assessments to ensure that staff were working in a safe working environment.
- Risk assessments were completed on an annual basis by the nominated individual within the team. These were then assessed by the risk lead in a different service to provide independent peer review. Once this had been undertaken, the risk assessments and action plans were reviewed and signed off by the directorate management team. This provided a robust systematic approach to identifying environment risks across community services. Risk assessment records books were audited annually and scored to provide assurance to the Board that community services were safe.
- We spoke with the member of staff who was responsible for risk assessments at one community nursing base. The resource was available on a shared drive for all staff to access as well as a hard copy kept in a folder.
- Some risks, for example if there were dogs at patients homes, would be logged on the communication board in community nursing staff bases and also on the electronic care record system. We saw this and also observed that these risks were discussed during the team handover.
- Staff in community equipment stores told us that staff would also document details such as these on equipment order forms.
- Community equipment store staff told us that they had safety processes in place to monitor the delivery drivers whereabouts.
- In the event of adverse weather, we were told that staff might need to prioritise urgent deliveries however this staff member also said 'all items are urgent if the patient needs them'. The drivers had scanning devices that logged when an item of equipment was delivered and this was automatically recorded on the electronic system; in addition to this, drivers were issued with mobile telephones however, it was acknowledged that in remote areas connectivity could be problematic.

Are services safe?

- We spoke to staff working in speech and language who also told us that they had a robust system in place for lone workers; they were aware of lone worker trust policy and completed e learning.

Major incident awareness and training

- The trust provided details of three major incident-training events that had been attended by staff from community health services. These included the following:
  - A local Test Scenario on 20/10/15. This was a table top exercise arranged by Harrogate & Rural District (HaRD) Clinical Commissioning Group (CCG) focusing on preparations for winter pressures. Six members of Harrogate District NHS Foundation Trust (HDFT) staff including staff from community services attended this.
  - A Community Outbreak & Pandemic Flu (NHS England) event on 19/11/15. Again, this was a table top exercise arranged by NHS England – North (Yorkshire & Humber) to test both the local responses to a community outbreak incident and separately, the arrangements in place for an influenza pandemic. Eight members of HDFT staff including colleagues from community services attended this.
  - A Communication & Networking Critical Incident Live Play Incident on 13/01/15. This incident affected the whole of HDFT including Community Services. This was completed in line with the NHS England emergency preparedness, resilience and response

(EPRR) framework and following a trust wide debrief session held on the 21/01/16 an action plan was in developed to respond to lessons learned during the incident.

- Senior staff from the community nursing and therapies team gave us examples of how major incident plans had been used in practice following the recent floods in the area.
- In addition, they told us about the action plans they had used during the Tour de France (Yorkshire) in 2015. This was something that could have potentially disrupted their services due to road closures and diversions that were put in place during the event.
- Staff in a podiatry clinic at York also told us about the contingency plans that were initiated during the recent floods in the town. This included restricted access to the clinic we visited, staff told us that all staff including managers pulled together. All patients were contacted and given alternative access details and all patients were able to attend their original appointments.
- Another clinic, was still unavailable at the time of our inspection, due to flood damage therefore capacity had been increased at three other locations. The patients attending this clinic had been contacted and offered new appointments in any of the three clinics.
- We were also told about a recent incident when the IT systems were temporarily unavailable at the acute site.
- Staff in community equipment stores had contingency plans to maintain the service in the event of an IT failure.

Are services effective?

Good ●

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 effective as good because:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. There was a centrally hosted clinical computer system, which allowed most staff to access and share records.
- Patients were receiving advice about pain relief. The trust was involved in audits to ensure that patient's nutrition and hydration needs were met in community settings.
- There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and benchmarking.
- Staff received timely appraisals and were supported with professional development.
- There was evidence of multi-disciplinary working across all teams and also evidence of collaborative working with the local authority. Referral processes were straightforward and staff did not raise any concerns about these.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. We saw evidence that patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

However we also found that:

- Although most staff had access to information via the trust intranet, staff at remote sites, who at times told us they felt isolated, experienced difficulties and frustrations in relation to the IT systems. This included a lack of IT support with aged equipment and also connectivity issues.
- Staff we spoke with told us that more effective mobile working devices for community nurses and therapists would reduce non-effective work time. However we were informed by the trust that actions were in place to address IT issues.

Detailed findings

Evidence based care and treatment

- Staff used a recognised electronic care record that ensured that patients' needs were assessed and treatment was delivered in line with current legislation, standards and evidence-based guidance.
- Policies were available on the trusts intranet and staff could access them. These also had references to best practice guidance.
- We asked the trust for copies of any care pathways that were used in community services and were provided with an integrated female urinary continence pathway and a stroke pathway both of which referenced NICE guidance. We also saw a cardiac rehabilitation pathway that did not have any references relating to evidence based care and treatment. Other than, some referral documents these were the only documents provided by the trust.
- We saw notice boards in community nursing and therapy bases containing guidelines for evidence-based care and treatment for example diabetes; incontinence associated dermatitis and wound care.
- We spoke with a speech therapist and witnessed a patient consultation. We found that the member of staff had an in-depth knowledge about the evidence-based care used for the service she provided including NICE guidance for dysphagia, dementia and stroke.
- We saw community nursing and therapy staff discussing best practice guidelines during their handovers.

Pain relief

- We observed community nursing and therapy staff assessing patients for pain and offering advice during home visits.
- A podiatry patient told us that the practitioner always asks about pain relief and also advises when treatment might be painful or uncomfortable.
- A senior podiatrist told us that they would signpost patients who needed pain relief medication but that part of their role was to also inform patients about non-medicinal pain relief methods.
- The trust told us that pain audits were not completed in community services however, this had been identified as a gap and work was underway to address this.

Are services effective?

Nutrition and hydration

- We saw community-nursing staff assessing patients for risk of malnutrition during home visits. We saw evidence of an audit to identify and manage adults in nursing care homes requiring oral nutritional support.
- Staff we spoke with told us that they advised patients with chronic wounds and pressure ulcers about the importance of adequate nutrition to assist with wound healing.
- We saw that community staff had completed audits relating to nutrition and hydration in community settings.

Technology and telemedicine

- We saw a robust IT system in place for ordering and delivery of equipment from the community equipment stores. We spoke with five staff at the equipment stores who all told us that the system was accessible at all sites.
- We were told that all staff were able to connect to the community equipment electronic ordering system because this was a public domain website. Each member of staff had their own username and unique identifier. A member of staff from the equipment store provided training. Staff had been issued with smart phones to enable them to access the system remotely.
- Staff we spoke with from speech and language and podiatry teams told us that IT issues can be challenging in remote bases due to connectivity problems. Concerns were also raised about processes being time consuming and that 'hot desks' were also an issue for staff who did not have a permanent base.
- Community nursing and therapy staff we spoke with told us they were duplicating work by completing paper records and that it was time-consuming returning to base to complete electronic records due to them not having mobile working devices.
- Staff in one wheelchair service base told us that their IT and office equipment was limited and out of date.
- A podiatrist we spoke with told us that the IT was 'appalling' in remote sites and can cause staff difficulties if they were unable to access the patients' electronic care record and information leaflets due to connectivity problems.

- It was recognised by staff that connectivity in rural areas may always cause difficulties but they told us that mobile working devices would reduce ineffective 'work time' if they did not have to return to a base to complete electronic records.
- Information provided by the trust indicated that work was being undertaken to address the IT problems experienced by staff.

Patient outcomes

- Senior staff in the community nursing and therapies told us that the teams contributed to national audits including the National Audit of Intermediate Care (NAIC).
- The aims of this audit is to assess progress against the NAIC Quality Standards established in the first two years of the audit, to assess performance at the national and local level against the key performance indicators and outcomes measures included in the audit, to review and continue to develop the patient reported experience measures (PREM) introduced in 2013, to develop standardised outcomes measures for home based intermediate care services, building on those developed for bed based intermediate care services in 2013, to continue to share good practice in intermediate care services and to inform future policy development within the Department of Health and NHS England.
- The matron for the community nursing and therapies team told us that the service was benchmarking and working with other organisations, including Calderdale and Northumbria to improve and develop the PREMs.
- The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. SSNAP measures the quality of care that stroke patients receive throughout the whole care pathway up to six months after admission.
- The trust community stroke team contributed to this audit. The data for the period April 2014 to March 2015 showed that in both team and patient centred key indicators scanning and thrombolysis were rated as worst and occupational therapy was rated as best.
- We looked at a re-audit of the identification and management of adults in nursing care homes requiring oral nutritional support, completed by community nurses. This included an action plan that showed collaborative working between health and social care.

Are services effective?

- In addition to the above, we also saw a community stroke team (CST) nutritional screening audit completed in 2015 that aimed to identify areas to improve the provision of dietary advice to patients. Again, there was an action plan associated with the audit.
- We saw evidence that the trust had participated in first National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme in 2015. We saw a document designed by the trust to disseminate the results, learning and areas for improvement from of the national audit.
- The Therapy Outcome Measure (TOM) allows professionals from many disciplines working in health, social care and education to describe the relative abilities and difficulties of a patient/client in the four domains of impairment, activity, participation and wellbeing in order to monitor changes over time. TOM has been rigorously tested for reliability and clinical validity. It is quick and simple to use, taking just a few minutes to complete, and is used for treatment planning, clinical management, audit and research. It allows for the aggregation of data so that comparisons can be made for the purposes of internal and external benchmarking.
- The community rehabilitation team were not collating any patient outcome measures. However, they had set up a focus group to look at implementing TOMS as their pre and post treatment outcome measure, for evidence, audit and further development of their service. We saw evidence of this working groups activity and progress.
- We observed a consultation between a patient and a speech and language therapist and saw that the therapist worked with the patient and encouraged the patient to set their own goals.
- The IPC team told us that they were completing work with the continence team to try to reduce the number of catheterised patients.
- Podiatry staff we spoke with told us that they discuss patient expected outcomes with each patient and we saw these documented in the electronic care records we reviewed.

Competent staff

- Staff appraisals were completed using the trust values.
- The majority of staff that we spoke with about appraisals told us that they were up to date. Many told us that these were reviewed every six months.

- Data provided by the trust showed that in 2012/13 90.04% of staff in community services had an appraisal, this fell in 2013/14 and 2014/15 to 83.4% and 72.4% however in the six months from April to September 2015 43.2% had been appraised therefore the service was on track to improve on the previous two years.
- A senior therapist told us about a clinical supervision (SUP) programme that was up and running in the community therapy team. This was the teams supervision programme; ensuring all levels of therapy staff received monthly clinical supervision with a more experienced colleague. This included looking at individual cases, caseload management, effectiveness and issues. Other staff members working in this team told us that they find the supervision very supportive.
- Staff working in speech and language told us that they had completed intensive interaction training to support people with severe non-verbal communication problems.
- Staff we spoke with in the speech and language team told us that they hold group clinical supervision sessions approximately four times a year.
- A senior member of staff we spoke with in a podiatry clinic told us that newly qualified podiatrists completed an online competency programme and had a mentor assigned for up to a year. A new graduate we spoke with confirmed that she had a band 6 mentor and was completing the on line competency pack.
- We were told that podiatry graduates were supported with their chosen area of expertise that could be general, nail surgery, high-risk diabetics or biomechanics.
- Senior staff in the podiatry teams had completed masters qualifications. We were told that all podiatry staff were expected to complete an element of structured self-directed study and that this was monitored through their appraisal. A second member of staff we spoke with confirmed this.
- Information provided by the trust indicated that staff in community services had completed post graduate education including:
  - Mentoring, managing minor illness, advanced assessment of the unwell adult, independent prescribing, district nursing, tissue viability & leg ulcer management, continence care & management, clinical leadership, diploma in diabetes, diploma in chronic obstructive pulmonary disease, diploma in

Are services effective?

heart disease, diploma in critical care skills, nhs leadership programme, emergency nurse practitioner skills, diploma in asthma and masters level qualifications for example in podiatry.

- One RN we spoke with told us that she felt that carers could be trained to carry out some tasks that were provided by community nurses.
- Senior staff explained that some of the staffing difficulties had arisen because nursing staff had left the service for career progression that had resulted in their being a less experienced team.

Multi-disciplinary working and coordinated care pathways

- The matron and senior managers told us about the vanguard project for the new intermediate care teams (ICT) which was being launched during the week of our inspection. This aim for this would be a multi-disciplinary team to coordinate and deliver the care to patients with complex needs. The team included district nurses, therapists, care support workers, pharmacists, long-term conditions practitioners, continence nurses, mental health staff and social care staff.
- Four registered nurses we spoke with told us that there was good MDT working, communication was good and referrals were easy. An example of this was if a community nurse felt that a patient needed a referral to a diabetic specialist or tissue viability nurse this happens very quickly.
- In addition staff working in community nursing and therapies told us that they worked closely and had good relationships with the local general practitioners.
- Speech and language therapists and staff in the fast response team reported good MDT working.
- We spoke with the lead for infection control in community services who told us that they complete joint inspections with social care and that they have good support from a consultant microbiologist.
- Therapy staff at the wheelchair services told us that they attended the Yorkshire regional group. This allowed peer review and benchmarking against similar providers.
- In addition, staff at wheelchair services told us that they had close working relationships with engineers and occupational therapists.

- Staff in podiatry told us that they had close working relationships with the musculo-skeletal service, orthopaedic team, joint clinics, vascular specialists and the diabetes and dietetic specialist nurses.
- Staff in the community stroke team held a weekly MDT where all patients were discussed and goals were reviewed and reset according to patient need.
- The tissue viability nurses told us that they worked effectively with discharge coordinators, social services and physiotherapists. The team were looking to improve their relationship with dieticians due to the importance of good nutrition in healing and the MDT needs of many patients.

Referral, transfer, discharge and transition

- Senior staff for nursing, therapies and podiatry told us that referrals were received via telephone or fax however all teams were hoping to develop electronic referral systems.
- There was a single point of access (SPOA) available Monday to Friday 8am until 5pm. The SPOA received the referrals for all specialist community services teams.
- In addition to this, a member of staff carried the 'team phone' to take details of new referrals from the SPOA and to receive referrals out of hours when the SPOA was not available.
- 1334 referrals were made in January 2016. We were told that most referrals were seen the same day but if capacity was limited, they were clinically triaged and deferred until the next day.
- Referral to the new ICT was via the SPOA. The most appropriate clinician would then triage the referral.
- Access to the ICT was available from 08:00 – 18:00 however once the teams were fully recruited to this would increase to 20:00. Overnight patients would be referred to advanced care practitioners would be able to assess and treat the patients. Community nurses provided a twenty-four hour service.
- Senior staff told us that the community rehabilitation team would 'in reach' (visit) patients at the acute hospital so that they get to know the patients who will be under their care in the community after they were discharged.
- Information provided by the trust indicated that podiatry waiting times were seen as a risk. We spoke to a senior podiatrist who advised that this was improving and we saw evidence of this in meeting minutes. The

Are services effective?

senior member of staff explained that waiting times could be reduced if patients were able to travel to different sites therefore sometimes waiting times were due to patients' choice of clinic.

- A senior podiatrist told us that clinic cancellations sometimes happen due to short notice sickness. A triage system was in place for these incidents. Staff try and re appoint urgent patients to an alternative clinic or ask a community nurse to visit. Routine patients were rescheduled. In addition to this, they had staff who worked flexibly.
- Information provided by the trust showed that during quarter three (October to December 2015) five hundred and thirty patients under the care of wheelchair services had their episode of care closed within eighteen weeks however, seventy-one, 13% of patients had waited more than nineteen weeks. Staff in this service told us that complex referrals requiring reassessment could wait up to fifty weeks.
- We observed an assessment in a wheelchair service. The patient told us that this was their first assessment and they had been referred in June 2015.
- We asked the trust for information about wheelchair service waiting times. We found that 83.3% (1243) of patients received their wheelchairs within ten weeks. However twelve patients had waited between thirty and thirty-nine weeks and one patient had waited forty-one weeks.

Access to information

- Staff were supported to deliver effective care and treatment by the use of electronic care records that included case notes, risk assessments and care plans. All community staff had access to this information however; remote connectivity was a problem and staff needed to return to their base to complete electronic records.
- All but three local general practitioner practices also used the same electronic system that allowed information to be shared as and when this was required.
- Paper records were kept in care homes; community nurses told us end of life patients in care homes also had electronic care records for health staff to access.

- Relevant policies and guidelines were available electronically via the trust intranet that was accessible from community bases.
- Staff were able to access blood and x-ray results electronically.
- We saw the electronic system used by staff to order equipment for patients' homes. We were told that when orders were delivered the member of staff received an e-mail to advise them of this. Community nurses confirmed this. All community nursing and therapy staff had been issued with smart phones to improve communication and to enable them to access the electronic equipment ordering system.
- We saw communication boards in use at the community nursing bases. These boards held patient information and staff resources including up to date information about pressure area care and pressure ulcer classification. Other information included diabetes federation global guidelines for the management of diabetes in the over 70's.
- Some staff in remote sites told us that connectivity and IT access caused problems for their services. We saw that these were discussed at team meetings.

Consent, Mental Capacity act (MCA) and Deprivation of Liberty Safeguards (DoLs)

- We saw evidence within the records on the electronic system that staff sought consent to share patient information.
- All staff we observed providing care and treatment sought verbal consent prior to providing care and treatment.
- Staff completed MCA and DoLs training as part of their statutory mandatory training Information provided by the trust showed that staff within this core service were 100% compliant with this training.
- Senior staff from the nursing and therapies teams told us that a mental health professional was now part of the new integrated care team. They hoped that this would improve services for patients in their own homes as prior to this, the service was 'patchy' and this had caused problems with the diagnosis of mental health illnesses.

Outstanding ☆

Are services caring?

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

Summary

We rated caring as outstanding because:

- Feedback we received from patients was consistently positive about the way nursing and therapy staff treated them. Patients told us that staff go the extra mile and we witnessed this during our inspection.
- We observed a number of staff and patient or carer interactions during our inspection. This included fifteen home visits and six observations during clinic appointments. We observed consistently caring and compassionate staff.
- Staff were highly motivated and inspired to offer care that is kind, promotes people's dignity, and involves them in planning their care.
- Patients said that staff were wonderful and amazing. One patient told us that she had felt trapped within her own body prior to being treated by one of the teams. Another patient's carer told us that the nurses visit was the highlight of their week.
- We saw staff providing detailed explanations of procedures, thorough assessment of all needs and reassurance.
- Relationships between patients, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.
- A member of staff in the equipment store told us that 'the patients always come first' and described all patients needing equipment as priority not just those who were classified as a priority.
- Patients were supported emotionally. All staff were very responsive to the psychological needs, not only of patients but also those close to them. We saw psychological assessment and depression-scoring tools being used for patients when appropriate.
- We received 174 comment cards during our inspection that highlighted positives about, in particular these related to the podiatry services. Only 1% (2) of these cards had any negative comments.

Detailed findings

Compassionate care

- We observed a number of staff and patient or carer interactions during our inspection. This included fifteen home visits and six observations during clinic appointments. We observed consistently caring and compassionate staff.
- During a home visit, we witnessed one patient saying to a member of staff 'I didn't know there were people like you to help'. This patient also told us that the staff were wonderful.
- We spoke to a patient following an assessment we had observed by a speech and language therapist. The patient told us that they were made to feel relaxed straight away and that they felt fully supported. They told us that their life had improved because previously they had 'felt trapped' within themselves.
- One patient's husband told us that their community matron visit was 'the highlight of the week'.
- A patient under the care of the community stroke team said they were 'amazing'
- We saw staff providing detailed explanations of procedures, thorough assessment of all needs and reassurance.
- All patients we spoke with spoke positively about the care and treatment that they had received.
- A member of staff in a community equipment store told us 'the patients always come first'
- We spoke to a patient following their podiatry appointment, this patient told us that he had been attending for appointments for four years and had no complaints. He said he had 'always received a good service'.
- The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed.
- We saw FFT data for the period January 2015 to December 2015 and found that although response rates were low, the majority of patients indicated that they would recommend the services.
- Staff in the community nursing and therapies team told us that they were using an automated telephone service to collate FFT data that was collated by an administrator. They told us that they hoped that this would improve response rates.

Are services caring?

- During our inspection, we collected comment cards. We received 174 cards for the community service teams. The majority of these, 169 (97%) related to podiatry services, the remainder were for community nurses. Of the 174, only two of the comment cards had negative comments. One patient was unhappy with the outcome of their treatment and one patient told us that they felt they had to wait too long stating that 'it's usually ok but not always'.

Understanding and involvement of patients and those close to them

- We spoke with patients and their families or carers. We were told consistently that staff involved them in their care and explained everything in a way that they could understand. Everyone we spoke with told us that they would feel comfortable asking for information.
- We saw a community nurse giving advice and support to the carer of a patient with dementia.
- Whilst observing a handover the nurse holding the team phone dealt with two calls that were not related to the team. One call was from a former patient's relative, the patient had died in hospital and the family had been unable to obtain a death certificate. The member of staff subsequently dealt with this for the family by contacting the ward at the acute hospital, establishing the details and then recontacting the family to advise of the outcome. The second call was also from bereaved relatives who were distressed about equipment that was in the house because it was not possible to arrange for the equipment store to collect the items the nurse herself said that she would collect the equipment that evening.
- Community nursing and therapy teams provided patients and carers with a pack of information leaflets. This included advice leaflets for example on nutrition and pressure area care. In addition, carers' information was also included and highlighted to patients' family or carers.

- We saw that staff maintained patients privacy and dignity for example a community nurse ensured that curtains closed in the patients home with the patients consent.
- We observed an assessment by wheelchair services of a patient and their carers. The staff provided a comprehensive explanation to all present and also gave the family an information leaflet.
- We saw evidence that discussions about self-management had taken place with patients where appropriate for example increasing medication and commencing antibiotics based on patients with breathing problems taking their own observations.

Emotional support

- We saw staff providing emotional support to the patients they were treating and also positive interactions between staff and the patients' carers.
- We were told that podiatry staff were very responsive to the psychological needs of patients who may need to have amputation performed and that they ensured that patients were supported.
- Clinical nurse specialists were available for support and advice, for example for diabetes and respiratory conditions.
- A community matron we spoke with told us that they used a psychological assessment and depression-scoring tool for patients when appropriate and we saw evidence of these in patients' records.
- One patient told us that they felt they could talk to their community matron 'about anything'.
- We observed a TVN consultation and saw that the patient was given good emotional support, the patients' anxieties around care were discussed and the patient was offered strategies to cope with self-care and pain.

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 responsive as good because:

- Services were planned and delivered in a way that meets the needs of the local population.
- The needs of different people were taken into account when planning and delivering services. Staff respected the equality and diversity of patients and their families.
- The facilities and premises were appropriate for the services being delivered.
- We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia, a cancer diagnosis and learning disabilities.
- The community nursing and therapies team provided a seven day 24 hour service.
- The community equipment store had moved from a five to a six-day service and staff we spoke to told us that they would be keen to extend this further.
- There were low numbers of complaints. We spoke with senior staff and found that there was an openness and transparency in how complaints were dealt with. Complaints and concerns were taken seriously and responded to in a timely way. Improvements were made to the quality of care as a result of complaints and concerns.

Detailed findings

Planning and delivering services which meet people's needs

- We found that services were planned to meet the needs of the local population. Services were provided at one hundred and thirty seven locations.
- The community nursing and fast response teams saw approximately 11,460 patients per month.
- Podiatry services saw on average 10,300 patients per month in seventy-seven locations.
- Community nursing services were available twenty-four hours a day, seven days a week. Community nurses assessed the needs of patients, planned the care package and provided nursing care to end of life patients.
- The ICT was a new vanguard project that was being launched during the week of our inspection. The aim of

the new service was to provide care, treatment and support in patients own homes and reduce the need for admission to hospital by providing a multi-disciplinary approach.

- The manager of the community therapy team told us that they provided a time limited service of six weeks for each rehabilitation patient. We were told that sometimes staff had difficulty exiting a care package after the six-week period.
- The rapid response team covered all of the trust area.
- Staff told us that their shifts allowed continuity of care for patients.
- The community equipment store operated a six-day service Monday to Friday and Saturday mornings. The locations of the equipment stores supported the rurality of the trust services in that they were positioned so that each store covered part of the location minimising long journeys.
- A senior member of the podiatry team we spoke with explained that patients can be seen in the location that was most convenient for them, this may be closest to their home or in some cases, patients attend appointments where they work.

Equality and diversity

- The matron for community nursing and rehabilitation told us that they had purchased portable hearing loops to assist patients who had hearing difficulties.
- We saw details about translation services displayed at community nursing and therapy staff bases.
- Staff we spoke with told us that interpreters were easily available when required and that a three-way phone system was also accessible.

Meeting the needs of people in vulnerable circumstances

- Community staff we spoke with told us that they were often asked for advice when visiting patients and they always seek to help patients find the information they require.

- One community nurse told us that the palliative care team provided support when required and were also able to review medications if this was needed.

Are services responsive to people's needs?

- We observed a community nurse providing reassurance in a caring and compassionate was to a patient who had a degree of dementia.
- We were told that the new ICT had a team of night sitters who were available to support patients in their own home and prevent admission to hospital overnight when social crisis happened.
- All staff attended dementia awareness training. We were told that non-clinical staff completed face-to-face training and clinical staff completed a higher-level tier 1 e learning module.
- The matron for community nursing and rehabilitation services told us that the trust had recently done work in relation to patients with learning disabilities (LD). This had included ensuring that a catalogue of leaflets were available in an easy read format.
- The trust had a dedicated community adult LD team.
- We spoke with a member of staff who had a patient with LD on their caseload. We saw that the patients' preferences were documented on their electronic care record.
- We were told that community equipment prioritised equipment for palliative and end of life patients to ensure that wherever possible a same day delivery was arranged.
- The IPC team told us that they had been able to obtain a leaflet for a patient in braille when this was needed.

Access to the right care at the right time

- Community nursing teams operated a twenty-four hour service with district nurses on duty between 08:30 and 17:00 and the fast response team on duty from 17:00 to 08:30.
- 85% of all referrals into the service between April and October 2015 were seen within a week. 40% of patients were seen on the day of referral.
- In podiatry 98% of patients were seen in under 18 weeks and the average wait was less than 10 weeks wait. Recent initiatives had reduced some longer waiting times from 37 weeks to 22 weeks and the numbers of patients on the waiting list had been reduced by 250 patients.

- There were some seasonal variations in waiting times; these may have been influenced by annual leave, staffing, sickness and maternity leave.

- Staff we spoke with told us that speech and language waiting times were up to 18 weeks for communication referrals and 2 weeks for swallowing difficulties.
- The tissue viability nurses provided care in the community and hospital setting. This included supporting district nurses with wound care.
- The podiatry service had developed a fast track plantar fasciitis clinic. This had been set up on an evening because the staff recognised that many people with this disorder were working.
- A podiatry patient told us that if he had a problem he could usually access a clinic the same day and that he had never waited very long for an appointment.

Learning from complaints and concerns

- We saw that community adult services received low numbers of complaints. Between September 2014 and January 2016 six complaints had been received, one was a complaint which also involved the patients general practitioner and another trust, three related to podiatry and two were about community nursing teams.
- A senior member of staff for community nursing and rehabilitation service told us about a verbal concern that she had received on the day of our inspection. This member of staff described that process she had used to address the concern.
- Another senior staff member told us that they did not receive many complaints but were able to describe how they would address any concerns or complaints and were also able to describe a recent incident.
- A senior podiatrist told us about the complaints that he had been involved with and we saw evidence of two comprehensive responses sent to the complainants. Both of these responses showed evidence of the service being open and honest and that the manager offered the patient an apology.
- The trust had a patient experience team who also supported patients and staff with complaints.
- We saw meeting minutes and team briefs that showed that the actions and learning resulting from complaints was discussed.

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 well led as outstanding because:

- The trust had a clear statement of vision and values, driven by quality and safety, which was recognised and integrated within the teams. Staff we spoke to were aware of and based their care around the trusts values.
- Senior staff shared details of the board and governance meetings with staff. Staff within the community service teams were aware of their risks and could explain these including any work that was being undertaken or that had been completed in order to mitigate their risks.
- Senior staff were visible and supportive to staff and patients. The majority of staff in the service told us that senior staff for the trust were also engaged with the services provided in the community. All staff we spoke with said that senior staff were very approachable. One said they had a 'fantastic supportive team, I love my job. I feel very well led and have never been happier.
- Leaders were actively engaged with staff, people who used services and their representatives and stakeholders.
- We witnessed the culture within teams as being team focused and positive. All staff we spoke with told us that they worked as part of a team and felt supported within their service.
- We saw good examples of public engagement within most teams.
- Staff were proud of the teams they worked in and told us about innovation they had been involved in. There was a strong focus on continuous learning and improvement at all staff levels. Staff shared innovations and improvement work that they were involved in.

Detailed findings

Service vision and strategy

- All staff we spoke with were aware of the trusts vision and values.
- We saw the trust vision and values displayed in all areas we visited.
- The matron and senior managers told us about the vanguard project (transforming community services) for

the intermediate care teams which was being launched during the week of our inspection. The strategy for this team was to coordinate and deliver the care to patients with complex needs. The team included district nurses, therapists, care support workers, pharmacists, long-term conditions practitioners, continence nurses, mental health staff and social care staff.

- As a service, we found that teams were looking for opportunities to improve the quality of the services delivered and teams were encouraged to develop ideas to make improvements.
- Staff we spoke with were aware of the vanguard and also spoke about other work that was being considered to transform community services.
- The tissue viability (TVN) staff told us that they would like to develop a local network of TVN staff across Yorkshire and to also develop greater links with dermatology, vascular clinics and diabetic foot clinics.

Governance, risk management and quality measurement

- Senior staff within the community service teams were aware of their risks and could explain these including any work that was being undertaken or that had been completed in order to mitigate their risks.
- We saw that the risk register for podiatry was discussed at team meetings.
- An RN we spoke with was able to tell us about the risks for community nursing teams for example staffing, capacity and pharmacy.
- A member of staff from a remote community equipment store was also able to provide details about the risk register for the service.
- Staff in wheelchair services were aware of the risks for their service. One risk was identified as being a broken transfer hoist that was resulting in staff being unable to appropriately assess patients.
- Staff identified a second risk being due to the loss of the repair service which was affecting patient waiting times and loss of income generation.

Leadership of this service

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- Senior staff within community nursing and therapies told us that they had been supported to complete leadership and complaints handling training.
- At a focus group managers told us that they felt empowered to act to improve services for patients
- Managers felt supported in career development and in supporting their staff
- We were told that morale with the community nursing and therapies teams was good but that senior staff were very aware that the service had been very busy recently due to vacancies and maternity leave. Senior staff said that staffing pressures were worrying.
- Senior staff told us that they liked to remain visible and accessible to staff to ensure that staff felt supported within the teams. We saw senior staff each time we visited a base, even when the visits were unplanned.
- Senior staff told us that the trust management team were approachable and visible.
- More junior staff in the rapid repose team told us that their direct leader was inspiring, supportive, effective and that they go 'extra mile'.
- Staff also told us that the matron was supportive and that she encouraged representation from all staff disciplines including domestic and administration staff to share their ideas and that she also encourages professional development.
- All staff we spoke with said that senior staff were very approachable. One said they had a 'fantastic supportive team, I love my job. I feel very well led and have never been happier. This member of staff had thirty years nhs service and four years in their current team.
- Some community staff who worked in remote bases told us that they felt disconnected from the trust and at times isolated. One member of staff used the example of being employed by Harrogate and District trust but providing a service many miles away from another trusts site.
- Podiatry staff told us that their senior managers supported them. More senior staff told us that their senior staff were visible. One member of staff said managers were proactive and supportive 'on a ridiculous level'.
- One therapist we spoke with told us that the safeguarding lead had been very supportive recently when they had needed to complete three safeguarding referrals in the same day.

Culture within this service

- A newly appointed operational manager told us that she had found a completely different culture to that where she was previously employed. This member of staff told us that she had gone from being a 'firefighter' to being encouraged to look at new developments for the service.
- We visited twelve sites during our inspection including community-nursing bases, several clinics, office bases and equipment stores. We found that staff were consistently positive, friendly, helpful and approachable at all sites.
- One therapist told us that they had left to work in another trust but returned, despite a longer commute to work, because they missed the team and the job.
- A member of a speech and language team described the team as 'open and transparent' and said that they would be happy to raise a concern. Another said 'we work together as one'.
- Staff in the community equipment store told us that they work well together and communication is good with the other sites.
- A student we spoke with told us 'everyone is super kind'.
- A podiatrist told us that there was a 'good energy' in the team and it was 'full of enthusiasm'.
- We visited two wheelchair service teams. Staff working in these teams told us that reductions in managerial and supervisory staff posts had caused disruption and concerns within the team. Staff in wheelchair services told us that they had a close working team however it was apparent that the staff in the two services we visited felt concerned about the organisational changes including their service being due to be retendered was causing anguish and concern amongst the staff.

Public engagement

- Senior staff in the community nursing and rehabilitation teams told us that felt that patient engagement within the teams had been low therefore they looked at ways of improving this.
- They told us about The Carers' Resource, which was an independent, award-winning Yorkshire charity. The resource was open to everyone and offers emotional and practical help to those who care for others.
- Senior staff told us that all patients now receive a copy of the Carers Resource leaflet in a pack that was left in the patients' home. We saw evidence of these when we accompanied staff on home visits and saw staff explaining these to patients and their carers.

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- Staff from the charity also visited each health centre and information about their services were displayed in community sites we visited.
- We saw staff giving written information leaflets to patients in their own home.
- A podiatry patient told us that he had been given written information and also good advice about self-care.
- A speech and language therapist told us about a voice group that was held monthly for patients with voice problems. We saw feedback from 30 users of this group all of which were positive.
- One patients relative told us that their community matron 'goes above and beyond' and that this member of staff has supported him despite him not being a patient.

Staff engagement

- Senior staff in community nursing teams told us that communication with staff was seen as a priority and that they were using social media for this.
- The community rapid response manager told us that they had tried different working patterns because staff were not going off duty on time. Staff we spoke to confirmed this.
- Senior staff told us that staff were rotating in to the hospice to gain end of life and palliative care experience.
- Qualified community nursing staff were being supported to complete the District Nursing and non-medical prescribing courses. Health care assistants were being encouraged to complete the foundation degree and being sponsored by the trust to access their nurse training.
- In addition, some more experienced staff, for example staff who already hold a district nursing postgraduate qualification were progressing to become first contact practitioners and completing courses in the management of minor illness.
- Staff in the therapies teams were being encouraged to complete the reablement diploma.
- In order to address any skills gaps the service were using the Calderdale Framework, which provides a systematic, objective method of reviewing skill, role and service design, ensuring safe, effective and productive patient centred care.

- Senior staff we spoke with told us that compliments were a standard agenda item at team meetings. A member of the speech and language team told us that staff were told when compliments and thank you cards were received.
- A senior podiatrist told us that they held a whole team away day once or twice each year. In addition to this, we were told that staff were given the opportunity to shadow specialist or more experienced colleagues to support and enhance learning.
- During our inspection, we observed a podiatry consultation where the podiatrist was also mentoring an undergraduate. We saw that this provided an excellent learning opportunity for the student. This included a discussion about anatomy and physiology, potential diagnosis, treatment and holistic care including self-care and also use of evidence based practice.
- Staff were aware of and appeared to be excited about the new vanguard ICT service that had started during the week of our inspection.
- Staff in the community equipment store worked in the base closest to their home.
- Staff in wheelchair services told us that they received the daily bulletin from the trust that helped with their integration with the acute.
- We were told by a member for staff working in the vanguard ICT team that an 'away day' was taking place to assist with team building.
- Prior to our inspection, we held focus groups for staff. We found that community staff feel valued and that the organisation were adapting to their services, for example mandatory training no longer all based at Harrogate Hospital. Staff were proud of teamwork and quality of care provided to patients. All grades of staff said they were supported to access training and all staff agreed that the trust was a good organisation to work for.

Innovation, improvement and sustainability

- The matron and senior managers told us about the vanguard project (transforming community services) for the intermediate care teams which was being launched during the week of our inspection. This aim for this would be to coordinate and deliver the care to patients

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with complex needs. The team included district nurses, therapists, care support workers, pharmacists, long-term conditions practitioners, continence nurses, mental health staff and social care staff.

- Staff we spoke with told us about the introduction of a new wound formulary, the ONPOS system and changes to the syringe Drivers used in the area. This included:

  - Wound Formulary: In order to improve the standards, clinical governance, clinical effectiveness and cost of dressings community services had launched a dressing formulary. This had been shared with local nursing homes and GP surgeries.

  - ONPOS: This was a new dressing supply project. ONPOS had been successfully trialled in the Ripon area and was to be rolled out across the area. Patients were receiving the dressings that they need more quickly and waste was reduced in the system as well as in reducing time for the District Nursing service. The matron for community nursing and therapies told us that they had evidenced that at times the new system had saved one hour of staffs time.

  - Syringe Drivers: Standardised syringe drivers had been introduced in community services. The acute hospital and the local hospice. 100% of community services staff had completed training. New prescription charts and syringe driver policy had been produced to underpin the training supporting this development.

- The trust IPC team had developed and launched their own website. . Staff in the IPC team told us that the website had a number of resources and was divided in to categories including policies, education, leaflets and articles.

- The speech and language team had piloted two Parkinson's groups. The patients attending this group had been asked for feedback and had suggested longer sessions, with a social element and that more were held. After evaluation, the group was due to recommence in April 2016 and would involve speech and language final year students supported by a speech and language therapist.

- The podiatry team won an innovation award in 2011 for the evidence based care package developed for plantar fasciitis. The team were also currently involved in a research programme. Two members of staff had been allocated non clinical time to complete this research which involved identifying patients who were at high risk of amputation in later life for example any patients who were over forty years old, obese, had deformities, were smokers or who were non-compliant with treatment. The initiative involved staff working with these patients to identify and try to address the risk factors to prevent them becoming high-risk patients. The aim was early recognition, identification and pre-treating to reduce the risk to the patient and also prevent the potential resource drain due to more complex care and treatment being needed in future years.

- In addition, the podiatry service were involving undergraduates in innovation. They referred this as undergraduate skills building (USB). Students were involved in collating FTT data; this was seen as a positive step due to the students being neutral to the patient and the service. In return, the service allowed students the opportunity to identify if there were any areas of practice that they would like to observe. One example of this was that the podiatry team had been able to arrange for a student to observe foot surgery with the surgeon and patients consent.

- The trust had a working group who were looking at the development and implementation of a single assessment tool and care plan across health and social care.

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met: care was

not always provided in a safe way as there was limited evidence of environmental and hand hygiene compliance together with a lack of an effective IPC audit plan or process and not all community medical devices had been serviced and maintained in line with recommended guidelines.

The service must:

· Ensure all community medical devices are subject to servicing and maintenance in line with recommended guidelines Reg 12(2)(e)

· Ensure there is an effective infection prevention and control audit programme for environments and hand hygiene. Reg 12(2)(h)