The Mid Yorkshire Hospitals NHS Trust

RXF

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

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

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

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

Summary of findings

Ratings

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

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Overall summary

Overall rating for this core service: GOOD

We rated services for community health services for adults as good, because:

- Staff were aware of their safeguarding responsibilities and procedures. We checked records and found them to be documented appropriately with the correct assessments in place. Senior staff had identified that record keeping needed to improve following the review of notes, as a result training took place and reviews of records showed an improvement in the records. Nutritional assessments were completed.

- Multidisciplinary and multiagency meetings occurred within different adult community services which discussed the ongoing care and needs of the patients. Referral criteria's and a single point of contact was in place were in place for patients and professionals could access the services. Ongoing work was in place to develop further multiagency working where professionals would be co-located in the same room.

- Patients and relatives felt involved in their care and thought staff were compassionate about the care they provided. This was reflected in the response rate for the Friends and Family Test and the high percentage of respondents that would recommend the service.

- The trust was responsive to patient's individual needs and planned to meet the local population. Services were developed around the patient, for example the district nurse clinics where patients had open access to attend the most appropriate one for them.

- Patients were seen promptly and extra patients were visited on the day as needed. Response teams were available to prevent hospital admissions and to ensure that the patient was safe at home in their own environment. A package of care could be provided to patients for early discharge from hospital to encourage independence.

- Senior management were aware of the issues within adult community nursing teams and steps had been taken recently to support and provide leadership. This included the movement of senior nurses and development of action plans. Staff had been involved in group sessions to look at the challenges within the service and solutions. From this an action plan was developed to work through the issues identified.

However:

- Targets set by the trust for NHS Safety Thermometer, harmful incident reporting and mandatory training figures were not achieved. Incident reporting was completed by staff who received feedback, however there was inconsistencies into which incidents they would complete these for.

- There was no transcribing policy in place for staff to transcribe from the patient's referral to the medication sheet. Also there were different medication sheets used within the community for staff to document they had administered medication.

- The majority of adult community nursing teams had vacancies and sickness rates significantly higher than the trust target. Some teams had vacancies for a long period of time with no extra staff to provide support. We saw that the sickness level and vacancies had reduced in recent months and steps had been taken to improve this. However at the time of inspection we were not able to see the full benefit of the changes.

- Further work needed to be undertaken to ensure that the correct data was extracted from the IT system to provide assurances that the correct response times were being met.

Summary of findings

Background to the service

Information about the service

Community health services for adults were provided by the trust under the Care Closer to Home division. The trust offered a range of adult community services from a variety of locations across the Wakefield district.

The registered patient population of Wakefield is estimated to be around 350,000 with a resident population of approximately 325,000 and is in the top 10% of deprived districts nationally with a life expectancy below the national average. Wakefield's health generally is worse than the England average with an ageing population and unhealthy habits which contribute to an increasing prevalence of long-term conditions and a higher level of attendance at Accident and Emergency than the national average.

There are currently forty GP practices within six networks, aligned to three community integrated hubs – Waterton, Civic and Bullenshaw hubs. These are known as connecting care hubs which encompasses health and social care such as nursing, therapy, voluntary services, pharmacy and mental health. MY (Mid Yorkshire) therapy was also part of the community hubs.

The care home vanguard was one of six enhanced health in care home vanguards across the country. It operates under Connecting Care, where health workers, local authority, voluntary organisations and private care home providers can work together to improve patient care and provide more joined up care. It prevents older people who are care home residents being transferred and admitted to hospital unnecessarily.

The trust also delivered adult community nursing which was separated into six networks across the district. Each network had varying amounts of community teams, for example network six had one large community team and network two had three teams. These six networks were:

- United Health Wakefield Alliance 1 (network one)
- United Health Wakefield Alliance 2 (network two)
- Network 3
- Five Towns (network four)
- Trinity Health Group (network five)
- West Wakefield team 6 (network six)

MY ICT (Mid Yorkshire integrated care team) joined together services that previously had worked separately such as rapid response, community therapies and dietetics service. This created one large team which provides rapid response and patient centred care to support patients who had been in hospital or in the prevention of unnecessary admissions. It also provided patient centred palliative care at home, intravenous IV therapy and out of hours care.

Community health services for adults was previously inspected as part of a comprehensive inspection in July 2014 and was rated overall as good. Responsive was rated as outstanding with safe, effective, caring and well-led rated as good.

At this inspection, we focused on all five areas: safe, effective, caring, responsive and well-led.

During our visit we inspected a range of services; including various adult community nursing teams in each network, MY ICT, podiatry, Bullenshaw community hub, Waterton community hub and the care home vanguard.

We spoke with 77 members of staff including, community matrons, community nurses, clinical support workers, therapists, community physicians, managers, administration staff and student nurses. We visited 29 patients and observed care provided in their own homes. We also held focus groups with community staff and reviewed performance information from, and about, the trust.

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Nurse Director

Team Leader: Sandra Sutton, Inspection Manager, Care Quality Commission CQC

Summary of findings

The team that inspected community health services for adults included CQC inspectors, a physiotherapist and community nursing specialists.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot 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 hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 16 to 19 May 2017. Prior to the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

Patients and their relatives and carers spoke very positively about the adult community services they received and the support available from all staff. Responses from the Friends and Family Test were constantly high ranging between 96% and 99% who would recommend the service.

Good practice

- The connecting care hubs encompassed a variety of different services; these included health and social care such as nursing, therapy, voluntary services, pharmacy and mental health.
- The care home vanguard was one of six enhanced health in care home vanguards across the country. It operated under Connecting Care, where health workers, local authority, voluntary organisations and private care home providers worked together to improve patient care and provide more joined up treatment. The aim was to prevent older people being transferred and admitted to hospital unnecessarily.

Areas for improvement

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

- Ensure that there are suitably skilled staff available taking into account best practice, national guidelines and patients' dependency levels.

Summary of findings

Action the provider SHOULD take to improve

- Ensure that the correct information is extracted from the IT system to record the correct percentage of response times for adult community services.

- Ensure that IT systems are available to be able to upload wound photography and wound templates to share with specialists that can review the patient care.

- Ensure that the trust completes a transcribing policy for staff to follow when administering prescribed medication.

- Ensure that the trust reviews the medication sheets used for administration and adopts one system for all the networks

CareQuality Commission

The Mid Yorkshire Hospitals NHS Trust
Community health services for adults
Detailed findings from this inspection

Are services safe?

Requires improvement 🟠

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Sickness and vacancy levels with the majority of adult community nursing teams were above trust target levels. This had impacted on staff caseload size and the ability to manage patient visits. We identified that improvements had been made to reduce sickness and vacancies but these had not been fully implemented at the time of inspection.
- The service had not met a trust target for the percentage of reported incidents that had resulted in harm. Staff were encouraged to report incidents, although there was inconsistency between staff in regard to what incidents they told us they would report. Learning from incidents was not shared across all the networks.
- There was no transcribing policy for staff to use within the community.
- There were a variety of medication sheets in use for patients who were having medication administered by adult community nursing teams. This had the potential to cause confusion when staff moved between teams.

- The trust did not use electronic imaging to photograph wounds which would enhance patient care.

However:

- Staff understood the principles of duty of candour and when to apply them.
- Staff were aware of safeguarding procedures and when to apply them.
- Equipment was available to prevent patient admissions or to assist with hospital discharges. Adult community services could order equipment to be delivered. The majority of equipment we saw had been calibrated and systems were in place.
- We saw 15 sets of records that were appropriately written and had the correct risk assessments and care plans in place. Documentation had improved in regards to pressure ulcers and information was available within the office to review the ongoing care.

Detailed findings

Safety performance

Are services safe?

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing of patient harm. The improvement tool focuses on four avoidable harms, falls, pressure ulcers, urinary tract infections in patients with a catheter (CUTI) and venous thromboembolism (VTE). The service did not collect data on VTEs.
- We looked at the safety thermometer data for adult community nursing for the period October 2016 to March 2017. Harm free care varied between 90% and 94% which was below the trust's standard of 95%. The lowest was percentage was in November 2016, afterwards this increased to 94% and fell to 91% in February and March 2017. The target for new harm was set at 2.2% which was met for four months in 2016-17 with three consecutive months from December 2016.
- The information was collected on a specific date each month and training was provided as some staff had difficulty in interpreting the form. We saw some of the data displayed in the adult community nursing base points.

Incident reporting, learning and improvement

- Staff were aware of how to complete incident reports and felt they were encouraged to by their managers. Most staff we spoke with said they would complete incident forms, however comments from staff varied when describing in what circumstances they would complete an incident form.
- The trust used an electronic incident form which allowed staff members completing the document to receive a response once it had been reviewed by a manager. Most staff commented that they did receive feedback in response to incidents they reported.
- There were 1,074 incidents reported between October 2016 and March 2017 for all adult community services, 714 of the incidents were classed as harmful (low, moderate or severe). The trust target for reported safety incidents that were harmful was below 50% each month. The target was not met for any of the months with the highest in 74.6% in January 2017 and had reduced for the next two months. The lowest month was November with 56%.
- Staff would complete incident forms for all patients that had a pressure ulcer. If the pressure ulcer was identified as a certain grade (category three or four) it would be classed as a serious incident and require further investigation using a root cause analysis (RCA) process.

- There were 32 reported serious incidents between April 2016 and March 2017 for all adult community services. The most common theme was the reporting of pressure ulcers which accounted for 91% of serious incidents. Teams had implemented methods to highlight the ongoing care of the patient and to ensure that the incident had been reported.
- We reviewed five RCA reports of serious incidents and found they were investigated thoroughly and fairly. Actions to prevent further reoccurrence and arrangements for sharing and learning were documented in the report.
- Pressure ulcer review panels were held for serious incidents involving pressure ulcers grade three and above, in order to establish whether they were avoidable or unavoidable. Staff told us they were able to attend and contribute to the meeting. Staff within the network where the RCA occurred were informed about learning; however, team leaders had identified that this learning needed to be shared across all six networks.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. There were no never events reported in adult community services between March 2016 and March 2017.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with understood their role in duty of candour and senior managers were aware of the process to follow. Staff were encouraged to be open and honest and discuss incidents with patients.
- Duty of candour letters were sent as part of the process for investigating serious incidents and we observed this within the RCAs we reviewed. We saw evidence of the named duty of candour lead meeting with the patient and family when requested.

Safeguarding

Are services safe?

- The trust had policies and procedures in place for safeguarding children and adults. Both policies were in date and provided staff with flowcharts to aid decision making and to ensure the correct processes were followed.
- Staff we spoke with knew how to access safeguarding policies and were clear about their safeguarding responsibilities. They were aware of the safeguarding team and confident they could access the team for support and advice.
- Staff within teams were identified as safeguarding champions. One staff member informed us that they were attending a safeguarding conference to develop their role.
- We observed in adult community nursing meeting minutes that overall 90% staff had completed safeguarding training, with 97% completion for safeguarding adult training. Information provided by the trust identified that the trust target was 95%. Adult community services were meeting the target for safeguarding training for both adult and children level one with 98% compliance. Level two was slightly below at 93%.

Medicines

- We saw that medicines were managed appropriately by staff. For the majority of adult community nursing teams, patient medication was prescribed by their GP or on discharge from hospital. This was kept in the patient's home and stored appropriately.
- Nursing staff administered medication from referrals written on the electronic record or from the patient's discharge hospital record. Staff documented on the paper based medication sheet the dosage required. We saw evidence that medication sheets were not always signed in the prescriber part for ongoing treatment. The trust did not have a transcribing policy; when we discussed this with the trust it identified that this was required.
- We were told that the referral information was available on the agile computer device; however, some areas identified that they had difficulty with connection so this information was not always accessible. We also observed that the original prescription was not always in the patient paper records. This meant that staff would not be able to view the system for the prescribed medication.

- We saw various medication sheets used during our visit that different networks used. We saw that this could have the potential to confuse staff who were asked to work in a different networks.
- We observed community nursing staff administer medication to patients and that they adhered to trust policies. Staff checked the correct details prior to administering the prescribed medication.
- Community matrons and district nursing staff were non-medical prescribers allowing patients to receive medications and prescription only dressings more promptly. Procedures were in place for safe keeping of the prescription pad.
- For patients receiving IV therapy equipment was given to each patient. We checked the equipment and found that the medication required was correct and in date.
- Pharmacy staff worked within the community hubs and visited patients to review medication and observe inhaler technique. Staff explored prompts with the patient to aid medication compliance and understanding.

Environment and equipment

- The majority of adult community services were provided from non-trust premises. A premises assurance audit was completed in March 2017. This looked at regulations under the Health and Safety at Work Act. Some of the adult community nursing teams had amalgamated and the rooms were not large enough to accommodate all the staff. We visited one area where a staff handover was taking place and the room was not adequately sized for the number of staff. However, as most staff were agile working the time allocated at the base point was minimal.
- District nurse and podiatry clinics were provided at some health centres which provided nursing care for non-housebound patients. We saw the clinic environments we visited had the appropriate equipment and were signposted.
- Equipment for patients (such as mattresses) were available from a contracted company. Some networks had identified issues with ordering priority equipment. In network two for one patient who was end of life the equipment was delayed for one day. This was escalated to senior managers within the community who met with the provider to look at the process.

Are services safe?

- Equipment was delivered with ease for patients to prevent hospital admissions or to assist in hospital discharges. If equipment was required out of hours, this was accessible to the team.
- Therapy services had stocks of frequently used equipment on site (such as zimmer frames and commodes) to ensure that these could be provided to patients without delay. A small supply of equipment was available at the three hubs which staff could take to patients quickly who required it. Small aids could be purchased for patients from MY ICT and hubs.
- Staff carried the appropriate equipment in order to be able to check the patient's observations when needed.
- Syringe drivers were used in accordance with National Patient Safety Agency (NPSA) Rapid Response Alert guidance. The same type of syringe driver was used across all the services.
- Syringe drivers in the community were held in local base points where they could be accessed easily. An appropriate system was in place to record where they were to be used and a system was in place for cleaning and decontaminating the machines. During our inspection we checked twelve syringe drivers which were all in date and the appropriate checks had been completed.
- We found three items of equipment that had not been calibrated within the correct timescales. We brought this to staff's attention who assured us that this would be completed.

Quality of records

- Patient information in the adult community services was stored securely on an electronic record system, and included paper records for medication which had been administered.
- We reviewed 15 sets of notes in the community teams and found risk assessments and care plans in place. These had been reviewed appropriately and reassessed. Every patient had information completed within a nursing assessment on the electronic record; this provided information about the patient daily activities such as pain control, ability to mobilise and aids required.
- Team leaders told us that documentation had improved over the last year in regards to record keeping for pressure ulcers. This had been evidenced with recent

RCAs where evidence showed that staff were documenting more information. We saw evidence within monthly documentation audits from February 2017 that assessments had been completed.
- Information provided by the trust identified that adult community nursing services were 85% compliant with information governance training. This was below the trust target of 95%.

Cleanliness, infection control and hygiene

- We saw staff used appropriate protective equipment such as gloves and aprons. Alcohol gel was available to all staff who also carried their own supply to patient's homes.
- We saw staff washing their hands before and after providing care and treatment. Patients told us that they also observed staff completing hand washing.
- Clinic areas we visited were visibly clean and we saw appropriate use of clinical waste and sharps bins. 'I am clean' stickers were evident on equipment and appropriate systems were in place for cleaning and decontamination.
- There were no cases of MRSA, MSSA bacteraemia and clostridium reported between March 2016 and April 2017
- Audits were completed regularly for hand hygiene and bare below the elbow compliance which met the 95% target. Information provided by the trust identified that adult community nursing services were 83% compliant with infection control training.

Mandatory training

- Information supplied by the trust showed that compliance with mandatory training averaged 94% between October 2016 and April 2107 for all adult community services. The trust target rate for core mandatory and statutory training (MAST) training was 95%. In services where it had been identified that staff were rates were low we saw evidence of plans to improve compliance. For example, staff within MY ICT identified that training compliance had improved and was 98% at the time of inspection.
- Services were expected to complete role specific MAST training and this averaged 86% for the same time period; the trust target was 85%.
- Within the role specific training staff completed wound care training to enhance patient care and improve the documentation. This included training for pressure

Are services safe?

ulcers and categorising pressure ulcers which had been identified within the RCAs. Information provided by the trust identified that between January and May 2017 compliance was 80%. Training was ongoing with specialist staff completing further training in the networks.

- Most staff we spoke with said they were up to date with their mandatory training and identified protected time was provided to attend. Some training had been cancelled due to staff shortages and staff had rebooked into the training. Each service received a report each month from the training department which identified who required to complete specific courses.

Assessing and responding to patient risk

- The adult community services completed risk assessments for patients as part of a core assessment on the electronic record. Risk assessments were carried out to identify patients at risk of pressures ulcers and malnutrition. Staff were aware of what action to take to protect patients from these risks. Staff were aware of how to refer patients on for specialist assessment or for the supply of additional equipment to manage these risks.
- Risk assessments were completed on a regular basis and care plans were generated for the continuation and review of patient's assessments. We saw that pressure area check care plans were in place to review periodically as within the trust policy.
- The adult community nursing teams reviewed the percentage of patients that received both a falls risk assessment (FRAT) and waterlow score (pressure ulcer assessment) on a monthly basis. The target was set at 95%. From October 2016 to April 2017 on average 98% received a FRAT assessment. The average score for the Waterlow over the time period was 93%. The assessment was not completed fully in previous months from April 2016 to November 2016, with 90% in October 2016. Since then there had been a marked improvement in completion of the assessment with 99% in February 2017.
- When patients were identified as having pressure ulcers, staff would refer to tissue viability in order to grade the pressure ulcer if community staff felt the grade was potentially a category 3, 4 or ungradeable. During our visits we observed that staff measured patient's wounds and recorded the information onto the wound care assessment tool. This was a paper based record and

could not be recorded onto a wound template within the electronic system. This meant that the ongoing care for the patient could not be reviewed by the tissue viability service on the electronic system. Work was in progress to resolve this. We saw evidence of staff referring to the tissue viability service who would visit the patient to assess the wound category of the pressure ulcer.

- Staff documented within the basepoint relevant information in regards to the ongoing care for patients who required care for pressure ulcers. This included a quick glance board that identified the potential grading of the pressure ulcers, referrals dates to tissue viability and incident reporting numbers.
- The adult community nursing teams did not use photography to assess and record wounds or allow the tissue viability team instant access to review potentially deteriorating wounds. We were told that one network did trial the use of authorised cameras although there was difficulty uploading the pictures. During our inspection we were told that team leaders had considered the purchasing of equipment that allowed the uploading of pictures of wounds into the patient's electronic record.
- We observed that one staff member failed to gain entry to a patient's home. Appropriate steps were taken to identify what may have happened to the patient and their safety.

Staffing levels and caseload

- The majority of adult community nursing teams had higher sickness than the trust target of 4% for most months between October 2016 and March 2017. The highest peak for most teams was between November 2016 and January 2017 where the highest level was 24%. This meant that there was less staff available and impacted on the ability to manage patient visits. The level had reduced and fluctuated over more recent months but remained higher than the trust target. For example in network three the rate had reduced from 24% in October 2016 to 12% in March 2017. In network one sickness rates were 6% in October 2016 where it started to increase steadily to 14% in January 2017 and began to reduce again.
- Current information provided by the trust showed that in March 2017 three of the adult community nursing networks and MY ICT remained above the trust sickness target, the highest was 14% and lowest 9%. During the

Are services safe?

inspection some staff identified that staff sickness had been a key concern and they felt that the issue was improving. Team leaders were working with human resources towards managing the situation and taking the appropriate steps in supporting staff to return to work where possible.

- In some community services including podiatry, MY community therapy, and connecting care hubs sickness was low and for the majority of months was below the trust target.

- There were staff vacancies in all six networks between October 2016 and March 2017. Some teams had larger vacancy rates than others. The latest data provided to us showed that in March 2017 network five had a vacancy rate of 17.3%, MY ICT 18.2% and network six 15.4%. This meant that less staff were available to meet the need for patient visits. For network four the vacancy rate had reduced from 4% in December 2016 to under 1% from January 2017. Staff also identified that a high number of vacancies had impacted on the team and the ability to manage the workload. In network five it was identified that there had been no qualified district nurse for 12 months. As a result an experienced district nurse moved into the area in January 2017 to provide stability and leadership.

- Some adult community nursing teams had amalgamated into larger teams; this increased the caseload. Staff were not working geographically which increased the mileage staff were completing and this reduced the time that could be spent with patients. Caseload sizes varied; for example Pontefract and Church View teams had approximately 800 patients, whereas Kings Medical Centre had 350 patients. Senior managers were aware of the challenges with larger caseloads and work was underway to review the existing large caseloads. Monthly reviews identified that not all adult community nursing teams caseloads were reviewed due to the capacity. This meant that reviews were not completed to ensure that patients were visited efficiently and discharged promptly.

- Staff were allocated variable numbers of patients per day to visit, depending on the patient's condition and capacity. There was no specific capacity tool in place within the adult community nursing teams to identify the balance of staff capacity to patient demand. Team leaders did look at the amount of staff on duty each day to the number of patients requiring visits. The number of patient visits varied within teams; during the day staff

were also expected to undertake unscheduled visits called SOS calls. These were extra visits where patients had contacted the service that day and had been triaged to identify a visit was needed. Senior managers identified that the future plan was to nominate an SOS nurse in each area who would be allocated the extra referrals that arrived during the day.

- We observed nursing handovers and found them to be comprehensive. Handovers provided a thorough knowledge of the patient's ongoing care. An overview of the meeting was recorded for staff to refer to who were not present. At the handover the staff member's ongoing visits were reviewed and shared between the staff in regards to capacity. Minutes were taken of handovers and saved within the computer system.

- Adult community nursing teams supported each other by offering to complete visits or staff temporarily moved teams for a period of time to support. Team leaders met twice a week to manage the staffing within the team and reviewed the caseloads daily to identify if further staff required to be moved to meet patient demand.

- High sickness levels had been present in some teams and team leaders worked with human resources to support people within the sickness policy. Some staff had identified that the policy had not been utilised to manage staff's sickness in earlier months. Team leaders had accommodated staff with ill health issues to return to work and offered flexible working.

- Staffing levels in MY ICT were reflected to identify the times where the service was most busy. More patients would contact the service for an unscheduled visit into the afternoon therefore more staff were scheduled to meet the demand.

Managing anticipated risks

- Adult community services adhered to the lone worker policy. Staff were aware of the policy and identified pathways that were in place. As part of the adult community nursing teams action plan lone worker files were completed and staff informed of the lone worker standard operating procedure. The single point of contact and out of hours team were kept informed of changes to the staff. Appropriate equipment was provided to all staff to ensure they were safe as lone workers and measures were in place for staff that worked out of hours.

Are services safe?

- Each team had access to a risk assessment file at their basepoint and this was reviewed on a regular basis. Staff discussed situations where risk assessments were completed and the processes and safety measures in place for visiting patients.

- Each service had access to its own business continuity plan. One example given was that if there was a phone line failure within the single point of contact alternative measures would be put in place in order for the service to receive referrals. Staff were aware of their roles in those circumstances. To support the plan in the event of an electronic malfunction, teams were expected to adhere to methods so they knew the identity of patients they were visiting. This including having printed copies of the caseload on a weekly basis to ensure that it was a reflection of the current caseload. Team leaders were aware that this teams did not always complete this process and further work was due to be undertaken to ensure this was adhered to.

- Adult community services had a winter weather plan in place and staff told us that they knew what to do in the event of adverse weather conditions that would affect normal service delivery.

Are services effective?

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

Summary

We rated effective as good because:

- Nutrition assessments were completed and reviewed as needed.
- Policies and procedures were based on evidence based care.
- The majority of staff were competent within their role. Where poor skill mix was recognised plans were put in place and training provided.
- MDT meetings took place regularly within the connecting care hubs where patient's needs were reviewed and reassessed.
- Referral criteria were in place for all the services and access into the services was through a single point of contact. This allowed patients to contact one number for their care needs.

However:

- Appraisals were below the trust target of 85% for the majority of months. However improvements were seen in individual teams where issues had been identified.

Detailed findings

Evidence based care and treatment

- We found that policies and guidelines were based on national and local guidelines. These were accessible to staff on the trust internet site. We saw that guidelines were developed in consultation with multidisciplinary teams.

- Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. They knew how to access the information and were provided with details when new policies were released. Of the three policies that we reviewed, each had an identified author or owner and each had review dates.
- Staff in MY therapy used professional guidance from the British Thoracic Society and College of Occupational Therapists and Association of Chartered Physiotherapists in Neurology.

Pain relief

- Pain was routinely assessed by adult community nursing teams as part of the patient assessment and recorded on pain assessment charts. We saw that staff had recorded patient's pain levels in the record.

Nutrition and hydration

- The majority of patient records we saw included an assessment of the patient's nutritional requirements. We saw use of the malnutrition universal screening tool (MUST) assessments and observed staff engaging with patients and carers to discuss their nutritional needs.
- The adult community nursing teams reviewed the percentage of patients that received a MUST assessment every month. From October 2016 to April 2017 the number exceeded the 95% target set by the trust.
- Dietitians were available within the community hubs and MY ICT. We saw that technical instructors worked with the dietitian and followed plans of care. We saw that food supplements were readily available for patients to try prior to ordering the supplements on prescription.

Technology and telemedicine

- The patient's record within the adult community services was held within an electronic system. Staff accessed the system within the patient's home and used minimal paper records. Community staff used laptops during their patient visits to record information onto the patient's electronic record.
- Connectivity was an issue for one of the networks. The majority of areas did not have connectivity issues and used the electronic record in the patient's own home. However, in network two staff identified that they had connectivity issues and so completed the patient record at the work base or at home. This meant that there was a risk that records were not available to staff at the time of the visit to receive up to date information.
- Some staff did not feel it appropriate to use the device within patient's own homes as they felt it impacted on the visit and acted as a barrier. The trust were in the process of running reports to identify issues with connectivity and staff usage.

Are services effective?

- An agile network standard operating procedure (SOP) had been written by community staff which was required to be ratified through the trust's governance processes at the time of inspection.
- The trust had an electronic patient record user group where staff could discuss difficulties or improvements to the system.

Patient outcomes

- The trust submitted audit schedules for adult community nursing which identified specific dates for submission. These included record keeping, pressure ulcer and monthly quality assurance.
- All calls to the single point of contact were recorded through an electronic system which provided a full audit trail. Information provided by the trust from October 2016 to April 2017 identified that 93% of calls were answered, this dropped to 72% out of hours.
- MY therapy service completed national audits, for example of pulmonary rehabilitation patient experience. The results were submitted to the British Thoracic Society. The service completed audits for the compliance of combined assessment therapist tool within the department (CAAT).
- MY therapy worked with patients using goals and outcome measures and used identified tools such as the BERG balance scale.
- Adult community nursing teams had key performance indicators (KPIs) where specific targets were required. These included a number of KPIs related to the activity including; the number of face to face contacts, the number of referrals and length of time on the caseload.
- MY ICT completed IV audits which identified how many bed days were saved as a result of receiving IV medication at home rather than in hospital.
- The trust participated in the NHS Benchmarking network dashboard report. This provided performance data on the services in comparison to other trust participating.

Competent staff

- Information provided by the trust identified that the appraisal rate for adult community services was below the trust target of 85% between October 2016 and April 2017: the rate averaged 78%. We saw within action plans

that this was being addressed where the compliance rate was low. In January 2017 the compliance in network five was 33% which increased to 100% by May 2017.
- Most staff we spoke with had completed a recent appraisal. The paperwork for appraisals had changed and staff found the process easier, more personal and focused on their own learning and progression. We looked at three appraisals and found them to be comprehensive and fully completed. Staff felt the process was positive and effective. We spoke with members of staff new to the trust who had a review of their role within three to six months of commencing the post.
- We spoke with staff new to the community and most staff identified that they had a comprehensive induction to community services. Staff felt supported and received adequate training and competency booklets to complete proficiencies. Time was allocated for staff to be supernumerary for a period of time; this varied for different staff members. One staff member told us they had a mentor for the first three weeks and then met with them as part of their preceptorship.
- New staff spent time on acute induction and also a two day community induction where specific skills were performed for their role. They spent time with the practice educator and other experienced staff who confirmed that the staff member was competent at completing a procedure.
- Information provided by the trust identified that in January 2017 it was noted that there was a poor skill mix in some teams. Plans were put in place to manage the skill mix, these included the movement of staff to allow for staff to achieve competencies.
- Health care assistants had completed further competency training to extend their role; this included medication administration and pressure area care. Health care assistants completed competency based frameworks to ensure proficiencies. We spoke with several health care assistants who expressed that there was no pressure to undertake tasks they did not feel competent with. Staff we spoke with identified they had completed training, were competent in the skill or working towards the proficiency.
- Due to teams merging into MY ICT, staff were required to learn new roles such as palliative care or rehabilitation. Staff were provided with training in order to become skilled in the area.

Are services effective?

- Within the adult community nursing teams there were staff that were link nurses or champions that led on specific areas such as IT and safeguarding. Staff were given the opportunity to develop in the role and attended meetings from which they fed back information to the team.
- Students who were undertaking the community specialist practitioner district nursing course were supported by senior staff members.

Multi-disciplinary working and coordinated care pathways

- The adult community nursing teams had effective links with the GPs they covered. Staff were often based within the surgeries and had effective communication channels. Due to staffing issues not all teams had attended regular meetings with the GPs, however plans were in place to manage this. We saw that staff communicated with the surgeries whilst at patient's homes which allowed for instant feedback to the patient.
- We saw examples of joint working with home care agencies and adult community nursing teams. For example staff from each service visited together to provide care for patients who were bed bound. This allowed the patient to receive care from the adult community nursing team prior to the home care agencies transferring the patient from the bed.
- Tissue viability services worked together with the adult community nursing teams to review the care required for patients with pressure ulcers. The team worked within acute services and supported the community staff by completing joint visits and reviewing the care.
- Staff also attended palliative care meetings with the GP. Community matrons linked with the GPs and discussed patient's ongoing care. One of the community matrons had been part of a vanguard pilot where they visited patients who required a GP home visit.
- Multi-disciplinary team (MDT) meetings were held weekly or two weekly in the adult community services; this allowed health professionals to discuss patients individually and to decide the involvement of services required. Teams provided a handover daily to their own team however the MDT meetings looked in more detail at the patient's care and the whole caseload.
- The community hubs which encompassed nurses, therapists, voluntary agencies, pharmacy, mental health workers and social services worked together in the best

interests of the patients. During our inspection, work was underway to renovate one of the hubs to allow further integration with the team. Staff told us of instances when they had referred patients to the voluntary services to support them staying at home.
- The care home vanguard worked with the residential care homes within the area to support the patient within their own environment. An MDT was held weekly with mental health, nursing and physiotherapy professionals where staff planned the care required for patients in residential and nursing care.
- Senior managers attended meetings with GP practice managers to discuss issues and raise concerns. Staff identified that they were visiting patients that were not housebound for various reasons and this was fed back to the CCG by the senior management team.

Referral, transfer, discharge and transition

- Patients were referred to the community nursing teams via a single point of contact (SPOC). The SPOC was one base where call handlers would receive the phone calls or referrals and refer on to the individual adult community nursing teams. It had been discussed if triage nurses were required within the SPOC base, however it was identified that this was not required. Staff within the SPOC would then input the details onto the patient's electronic record and task the appropriate team with the information.
- Within the community teams one staff member took the lead role of co-ordinator; their responsibility was to manage the referrals and tasks assigned to the team. Teams managed the role slightly differently and this was dependant on staffing. Some triage staff completed patient visits which meant there may be a time delay in answering the requests sent to the team. We observed the triage role and saw staff making appropriate clinical decisions and identifying the care that was required.
- At the weekend, district nurses based within the SPOC provided a co-ordinator role for the geographical area.
- Out of hours, the SPOC transferred incoming calls to MY ICT where calls were answered by one of the senior nurses on duty. The staff could be potentially out visiting patients and this could delay the call being answered.
- Referrals for the community hubs also had their own SPOC where the referrals and calls were triaged by a therapist. Work was under way to change the process of

Are services effective?

the SPOC; the future plan was to see both health and social care calls triaged in the same SPOC however different premises were required to manage the influx of staff.

- A referral criteria was in place for all the adult community services which reflected the requirements from their service specifications. Some staff within the adult community nursing teams identified that the criteria was not always adhered to. This meant that teams were busier visiting patients that did not meet the criteria. Senior managers were aware of this and discussions were taking place with the GPs and CCG. Criteria were provided which identified patients that may need to be seen by the emergency assessment team (EAT). This team provided same day visits for patients who were at risk of hospital admission if they were not seen.

Access to information

- Most GP surgeries used the same patient electronic record which allowed both the adult community services and GP to see the progression or deterioration of a patient. We saw patient electronic records where the GP had reviewed information documented by the nurses and acted in response to provide further medication. We saw staff use the system to contact health professionals, during a home visit the staff member used the instant message system to request a prescription needed for the patient. This allowed the staff member to feedback directly to the patient and provide them with further information.

- A 'PIC' (personal integrated care) file was to be implemented, this would allow access for staff to see appropriate parts of the patient's record and provide for continuity and improved patient care.
- Staff within the adult community nursing teams had limited access to the acute hospital's computer system. During one of the patient visits it was identified that the patient had been admitted to the trust's acute hospital site, however the staff member could not see why the patient had been admitted. This meant that the community teams could not be involved with the patient's care and potentially allow an earlier discharge.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed that staff obtained consent before performing any observations or providing patient care.
- Mental capacity assessments and best interest information was identified within the electronic record; staff completed this as appropriate.
- Information provided by the trust identified that adult community nursing services were meeting the target for Mental Capacity Act training at level one and two. In some areas 100% of staff had completed the training.
- Staff we spoke with were able to articulate the requirements of the Deprivation of Liberty Safeguards (DoLS). There were no patients at the time of our inspection that had this in place.

Are services caring?

Good ●

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

Summary

We rated caring as good because:

- We observed staff providing compassionate and supportive care within the home environment.
- We observed staff maintaining privacy and dignity of patients when providing care.
- Patients were encouraged to be involved in decision making and staff communicated and worked together to plan the care and treatment.
- Staff helped patients cope emotionally with their care and treatment.

Detailed findings

Compassionate care

- We observed staff providing care and saw that they were respectful and caring to patients. Privacy and dignity of the patient was maintained during the interactions.
- Staff were sensitive and compassionate in the way they discussed aspects of care with the patient and family. Staff engaged with patients to introduce themselves and listened compassionately to patient concerns.
- We spoke with 29 patients and relatives who used the services; all were consistently positive about the care they had received. Staff were described as being 'very good' and 'smashing'. They also thought that staff were very kind and friendly.
- Compassion and professionalism was shown by staff to their patients. One instance we observed was of a patient who was refusing treatment. The nurse showed empathy and sat with the patient and listened and encouraged them.
- We saw that the adult community services worked around the wishes of the patients. One example was the time they visited the patient as they were aware of their routine and the times they slept during the day. However it was not always possible to provide times for all patients due to the demands of the service.

- Information provided by the trust identified the friends and family test results for all adult community services, which showed that the results were consistently positive. We found that between October 2016 and March 2017 96% to 99% of patients would recommend the service

Understanding and involvement of patients and those close to them

- We spoke with 29 patients and relatives who all said that they were involved and participated with their care.
- We observed staff involving patients in their care in a way they could understand. We saw staff speak with patients on the telephone and ensure that they understood the conversation.
- Patients commented that they felt involved in their care and described being included in the decision making about treatments they received.
- We saw evidence of staff respecting patient's views. During one patient visit, the patient did not want to have pressure relieving equipment or sleep in the bed. Staff involved the patient and documented the appropriate advice given and reviewed their information on a regular basis.

Emotional support

- During our home visits we saw that staff supported patients with their emotional needs. We observed staff interacting with patients and relatives in a supportive and reassuring manner. They spent time with the patients and listened attentively.
- Within the community hubs patients could access mental health support from the mental health team. Adult community services explained that they could easily access support, guidance and referrals for patients who may have additional emotional or psychological needs.

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 in a way to meet the individual's needs and the local population.
- Vulnerable patients were supported by services to remain safe and stay at home where they wished to be. Translation services were available for staff to use.
- Complaints were minimal and managed within the services and within the trust's timescales.
- Staff responded to patient emergency calls and provided care and treatment promptly. Systems were in place for patients where scheduled visits were delayed and with services that required waiting times.

However

- Further work needed to be completed within the IT service to ensure the correct data was compiled from the system to show the response times for services.

Detailed findings

Planning and delivering services which meet people's needs

- The trust worked with commissioners to identify the specifications required for the community services.
- Teams were reorganised and redesigned to meet the movement towards more integrated working across different agencies. MY ICT was reconfigured to include palliative care, IV service and out of hours to work together rather than working separately.

- Connecting care had developed a joint operational delivery group (JODG); the meeting was a solutions-driven forum in relation to the redesign of the service. The connecting care hubs were to be redesigned to incorporate two hubs, these had been agreed to be at Bullenshaw and Waterton.

- Centralised clinics were developed to replace individual district nursing clinics. This allowed patients to attend any clinic of their choice and allowed for greater flexibility.
- Vanguards such as MCP and care homes in the area supported and enabled patients to avoid unnecessary admissions. Within the care home vanguard a range of partnerships were used, such as the voluntary sector. They had also received funding for positioning equipment and were working with care homes to purchase their own equipment.

Equality and diversity

- A telephone translation service was available, and staff were aware of how the service operated. None of the staff we asked had needed to use the service.

- All the leaflets we saw were in English, but we were told they could be provided in other languages when needed.
- We observed that the community premises we visited and used by patients had good disabled access, with accessible toilet facilities and clear signage which complied with the NHS England Accessible Information Standard.
- A number of patients had restrictive disabilities and were house bound and unable to answer the door. Adult community nursing teams could gain access to the premises via key safes, which were set up in conjunction with social services and the family.

Meeting the needs of people in vulnerable circumstances

- The community matron service offered support for patients with long term conditions and complex physical health problems. They also acted as a specialist nursing support for the adult community nursing teams.
- MY ICT provided support for patients who had fallen or were at risk of falling. Patients were assessed by the therapy team and then a package of individual care was created and provided by the team. This enabled the patient to remain at home, to increase their confidence and independence.
- The care home vanguard supported patients and allowed them to stay within their own environment.
- We saw that nursing and therapy staff liaised with other agencies, families and carers to maintain routines and support patients in vulnerable circumstances.
- We observed examples of staff supporting patients to maximise their independence. One example of this was pulmonary rehabilitation. The service had set up an

education programme where staff were able to support patients to develop their confidence in managing their long term conditions and promote greater independence.

- Nursing assessments identified patients living with dementia or learning disabilities and care was provided to meet their needs. Staff could give examples of how they had supported patients living with learning difficulties. Teams had identified dementia champions to support and provide information to others.

Access to the right care at the right time

- Referrals to the community hubs were triaged and visits were available for emergency visits each day; staff were allocated specifically for this reason. Specific response times were required to be met, for example to react to a patient in crisis a response time was required of two hours. Emergency assessment teams (EAT) were available between 8am and 6pm to meet this. Information provided by the trust identified that at present the system does not allow the response times to be extracted to show the evidence. The trust were assured that the response times were being met and were developing strategies to the system to capture the information.

- During our inspection we saw a patient that was referred due to recurrent falls; the patient was seen on the same day by both the physiotherapist and OT. The patient received equipment the same day to prevent further falls. We also saw that one patient required a stair rail for the door which was supplied and fitted within 30 days.

- We were told that equipment could be requested urgently to prevent hospital admission and the patient care package could be provided at home. An emergency stock of equipment was also available at the hubs for staff to provide quickly to patients.

- MY ICT also provided rapid response to patients to prevent hospital admissions. It provided patients with an IV therapy care package which allowed patients to be discharged earlier from hospital. In April 2017, 16 patients received care for IV therapy with 187 bed days saved.

- Some scheduled visits within adult community nursing teams needed to be moved due to the amount of patient calls and staff could not complete all the visits on that day. This was due to staff sickness and vacancies. Staff felt this had improved in some teams

due to more staff being available to complete the visits. A system was in place to identify which visits could be safely rescheduled and documented. Staff explained that the number of patients requiring to be deferred had reduced recently and for some teams this was no longer an issue.

- Patients that contacted the service and required a visit the same day were known as SOS visits. These visits were added to the staff's workload and were seen during the day. Response times were required to be met dependant on the criteria; these were: immediate – within two hours, urgent – four hours or non-urgent – within 7 days. Information supplied by the trust identified that there were high levels of SOS visits to be made by staff who already had existing patients to see. For all six networks in February 2017 361 extra visits were completed, 425 visits in March 2017 and 416 visits in April 2017. Some teams had identified the possibility of having a dedicated SOS nurse to visit the extra patients however staffing levels within the teams had not allowed this to date.

- Response times were part of the KPIs for adult community nursing where a 95% target had been agreed. Response times were measured, collated and reported to the CCG. Information provided by the trust identified that the target was not met for both immediate and urgent visits between October 2016 and March 2017. The information identified that for immediate response visits in February 2017 there was a response rate of 52%. We discussed this with senior management within the community who had identified that the data recorded within the system was incorrect. They assured us that the information was inaccurate and work was ongoing to extract the correct data from the system. We also spoke with the IT manager who stated work was ongoing with staff as to how to input the referrals to record the information to provide accurate data. All staff we spoke with confirmed that they responded to visits in accordance with the response times and were not aware that they were not meeting them.

- Several patients said that they had swift responses when requesting visits. We saw that a patient was seen in response from another health professional within three hours for wound care. During our inspection a patient in a residential care home was visited as an SOS

Are services responsive to people's needs?

visit that had contacted the service the same day. Staff from the care home confirmed that the adult community nursing team would respond and visit promptly.

- Most adult community nursing teams identified that they had a waiting list for patients that required visits for continence care. Some patients had been on the waiting list between three and five months. Patients were advised to buy their own products until an assessment could be completed. Information provided by the trust showed that 228 patients were due a continence assessment in April 2017. This varied within teams; network five had 75 outstanding assessments and network three had none. Teams had looked at ways to reduce the waiting list which included providing staff with designated days to review and manage the list. Staff showed us visits they had completed and how they had reduced the waiting list. . Staff had requested a continence leaflet for them to give to patients waiting for an assessment.

- The pulmonary service had waiting lists in the areas where the service was provided. The average waiting time for initial assessment was nine weeks however where the service was provided at Pontefract General

Hospital the waiting time was 6.6 weeks. Information from the trust identified that the longest wait for an appointment was 18.6 weeks and the shortest time was 1.6 weeks.

Learning from complaints and concerns

- Patients received PALS leaflets provided by the adult community services which provided advice on how to complain. We spoke with patients who told us that they were comfortable about raising concerns with staff.

- Information provided by the trust identified that 25 complaints were received between October 2016 and April 2017 for all adult community services. All the complaints were acknowledged, investigated and responded to within the trusts timescales.

- Staff were aware of complaints and tried to deal with them informally. Some of the complaints discussed were that various different staff visited leaving the patient with no continuity and unable to offer specific times that the nurses would visit. One patient identified that they struggled for their phone call to SPOC to be answered out of hours. Rationales were given and staff discussed the issues with patients to look at resolutions.

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 good because:

- Senior management within the community were aware of the issues and plans had been developed to manage them. These were reflected within the divisions risk register and discussed at governance meetings.
- Recent changes had been made to services to improve leadership and action plans had been created to ensure robust plans were followed and implemented. These were created in January 2017 and improvements were seen within these plans.
- Connecting Care had their own vision which incorporated other agencies and working together to meet the needs of the patients in the community.

However:

- Further work was required to take place with the patient, family and carer strategy project and to develop the public engagement.

Detailed findings

Leadership of this service

- The chief executive had visited base points within adult community nursing teams where time was spent with staff asking about their challenges and concerns.
- The Care Closer to Home division was led by the director of operations who attended board meetings where community services issues were discussed. Staff told us the senior management team within the community were approachable and visited the teams on a regular basis.
- The director of operations was supported by the head of therapies, nursing and group manager who oversaw different services. The management team visited the adult community nursing team at Pontefract and had recognised the hard work that the staff performed.
- We spoke with the matron who was aware of operational issues within the adult community nursing service. The matron met with team leaders on a weekly basis and discussed ongoing issues.

- Senior managers held listening groups with the adult community nursing teams to identify key themes and issues. A project plan was put into place from March 2017 where 27 key challenges were discussed. From these solutions were provided and created to manage or resolve the challenge. These included a phlebotomy service to complement the teams and review skill mix. Other roles were to be developed such as a tissue viability nurse and leg ulcers specifically for the community.
- Senior managers had identified that leadership had been an issue over a period of time. Some adult community nursing teams had experienced several managers or vacancies within senior roles. Staff had been moved around to support teams that were struggling. Some teams had developed action plans in January and February 2017 as a result of issues within the teams. These included one to one not being performed, lack of team meetings and no robust methods in place for reviewing the caseload and capacity. We looked at some of the action plans and found robust actions in place and vast improvements to the teams.
- Some staff at a senior level had completed an in-house leadership programme called circle of excellence. This allowed staff to develop leadership skills and provide coaching skills.

Service vision and strategy

- The adult community nursing services were aware of the trust vision and strategy. Individual services had their own service vision and strategies. Due to the changes within MY ICT and the merging of teams, they had developed their own philosophy and ethos which reflected the trusts.
- Connecting Care had provided its own vision and created a vision and blue print document to look at the service between 2016 and 2019. It was based around the NHS 5 year forward view and reflected the ambition for integrated planning and delivery of a quality seamless service.

Are services well-led?

Governance, risk management and quality measurement

- Risks for community services were included in the divisional risk register. Risks we identified during our visit were on the register such as the continence waiting list, reduced capacity, equipment delays and inability to respond to SOS calls in a timely way in MY ICT. The risk register also identified specific risks for teams such as network six who were experiencing high levels of sickness and there was a potential risk of patient visits being unmet. The risks were rated in terms of severity and reviewed within a current time period. Ongoing actions and summaries were completed in action plans.

- The division were aware that the correct information was not being extracted from the electronic patient system to provide details of response times. As a result the division was working to develop how the services use the system and make changes to capture the correct information to provide assurances.

- As part of the redesign of Connecting Care a multi-agency meeting took place monthly where actions and information was cascaded. From the meeting four task and finish groups were designed that would develop and shape the service.

- During the meetings with the matron and team leaders within adult community nursing, action plans and the ongoing challenges and solutions action plan was updated. A community nursing priorities register was created with the issues identified that would be used to feed back to the senior and executive management teams. Specific networks action plans were discussed and renewed.

- Team leaders met weekly to discuss the concerns within the adult community nursing teams and how to manage them. A capacity and demand report would be completed daily by team leaders to look at which teams required further staffing and support.

- Each week a sister meeting was held where issues were discussed that had been highlighted in the team leader meeting. A meeting took place monthly where any staff member could attend.

- Staff had identified that at the beginning of the year when staffing was critical, team meetings did not always take place. Most teams felt that this had begun to change and teams had regular meetings. We looked at some team meeting minutes and found that they were comprehensive.

- The trust had identified that there were issues with the electronic system and how it extracted incorrect information. Staff were implementing method to resolve and ensure the correct information was provided.

Culture within this service

- Morale within some teams was low which staff said was attributable to the constant unmanageable workload and staff felt the work life balance was inconsistent. Some teams felt that their workload was manageable. Staff discussed the morale at the listening event where solutions were looked at such as dedicated SOS nurses and team leaders to review the size of the networks. Team leaders told us that they had looked at changing some of the geographical areas between the networks to support teams.

- Many staff identified that between November 2016 and February 2017 the staffing and caseload demand impacted on the ability to manage their role, some staff left due to the stress this was causing. The majority of staff told us that they felt that morale was improving and the 'feel' of district nursing was changing. They felt that staffing was improving and action was being taken as to how they were feeling.

- We saw that staff identified in their appraisals and meetings that they felt more supported now they had more senior nurses cover within the team.

Public engagement

- Care Closer to Home had in place a patient, family and carer experience strategy project plan. The plan included sending letters to patients outlining waiting times for appointments and using agile devices at the patient's house. The plan was limited in information with no operational leads for seven of the 17 tasks and no documentation of ongoing progress.

- Within the care home vanguard, care home staff turnover had presented a challenge. The team had identified this and provided bespoke and one to one training for residential home staff in order to provide a more seamless care package. This in turn helped to prevent unnecessary hospital admissions.

- Teams encouraged patients at their visits to complete the friends and family test. MY ICT had increased the response rate; in February 2017 only 10 responses were

Are services well-led?

received. In April 2017 this had increased to a response rate of 72. Responses were reviewed from the FFT and five out of 20 of the key themes identified were part of the trust's priorities for improvement.

Staff engagement

- Staff events were held to inform them of the changes within the connecting care hubs and work streams implemented where staff participated.
- Within adult community nursing staff consultations had been completed where roles and times were altered for staff. We were informed that staff were given choices and asked to trial different shifts that had been suggested.
- At one the hubs staff devised specific SOPs, these were discussed with staff and changed to reflect their comments.
- Staff within the community in particular the community hubs had received MY star awards which were given to staff for commitment and patient care.

- Staff surveys were completed for the adult community nursing services and groups looked at the findings. Staff motivation with MY therapy had improved since the last staff survey.

Innovation, improvement and sustainability

- One staff member within the Bullenshaw community hub was presented with an award that had noted the high level of caring and compassionate attitude towards the community patients that they visited.
- Staff within the care home vanguard had completed radio broadcasts, published within journals and attended conference to discuss the development and progression of the service.
- A red bag initiative was launched in May 2017 to improve and speed up transfers between hospitals, ambulance and care home settings. Each care home has received a red bag to keep important information about a patients care, including transfer documents, medication, and consent information. The bag had room for personal belongings which remained with the patient whilst they were in hospital until they returned home.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of patients.** • There was not always enough staff available to provide patient care to the expected numbers of patients using the service.