Care Quality Commission

Humber NHS Foundation Trust

RV9

Community health services for adults

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

An electronic incident reporting system was in place, however staff's understanding and reporting of incidents was inconsistent across the teams. We were not assured that all incidents were reported appropriately.

We found hygiene and cleanliness, the environment and equipment were well managed.

There were three systems used to record patient information. There was duplication and a risk of transcription errors. We found that in records reviewed, information had not been fully transcribed and found transcription errors in some records.

Staffing and caseloads varied across the teams. There was no robust, embedded system to determine appropriate staffing and caseload size, particularly for community nurses.

Staff had access to evidence-based guidance and we saw this was followed in practice.

There was limited participation in clinical audit. The trust's clinical annual audit plan for 2013/14 detailed no audits for community nursing with the exception of the trust's record-keeping audit. Therapy staff in East Yorkshire told us they did not have time to conduct any audit activities.

Staff were competent and worked well in multidisciplinary (MDT) teams. We saw evidence of coordinated integrated care pathways, in particular mental health services and telemedicine services were provided by the Community Services team in partnership with Hull and East Yorkshire Hospitals NHS Trust.

Staff treated patients with dignity, compassion and respect. Patients and their carers and families spoke positively about the care and treatment they received. They also felt involved in their care and supported with their emotional needs. We found limited information about bereavement and counselling services to support patients or their relatives. However, the trust was in the process of addressing this.

Referral to treatment times for podiatry in Hull and the East Riding of Yorkshire pulmonary rehabilitation service was 28 weeks and 19 weeks respectively against targets of 18 and 10 weeks. Service specifications were not in place for some services such as the occupational therapy and the speech and language therapy service. This meant staff were not clear about the service they should be providing in their areas.

Some community nursing teams were below the 100% target for the proportion of preventable or urgent referrals seen within four hours. Some teams were also not meeting the targets regarding initial and follow-up visits to patients.

Staff adopted a flexible approach to the delivery of care to patients, who could be referred to the services in a variety of ways. There were systems in place to support vulnerable patients.

Complaints were managed effectively, but feedback was not consistently shared to help staff learn from them.

Senior staff clearly expressed the trust's vision and values and they were positive and proud of the work they did. However, staff at more junior levels were uncertain about the vision and strategy.

There was effective teamwork and visible leadership across most teams apart from therapy staff who felt under-represented at a corporate level.

Systems were in place to disseminate information about quality and risk such as quality circle meetings. Local risk assessments were available and updated.

Staff spoke positively about local leadership of services. Feedback from patients was gained in an ad hoc manner.

We saw examples of innovative work across many teams in the trust.

Summary of findings

Background to the service

Adults with long term conditions received services in their own homes from support workers, district nurses, community matrons and therapists. Community teams were part of community neighbourhood teams that included mental health teams based in eight localities.

There was also a range of clinics in the community offering specialist services. Community nursing and therapy services were commissioned to be provided to East Yorkshire. Some therapy services were also provided in the Hull area.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust

Team Leader: Cathy Winn, Inspection Manager and Surrinder Kaur, Inspection Manager, Care Quality Commission (CQC)

The team for adults with long term conditions included three CQC inspectors as well as a deputy chief nurse for community health services and a respiratory nurse specialist.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot for mental health and community health services inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 20 to 23 May 2014, and an unannounced inspection on 5 June 2014.

During the visits, we held focus groups with district nurses, therapists and specialist nurses. We visited community teams based in each locality in East Yorkshire. We also spoke with over 90 staff at different grades including district nurses, community matrons, therapists, specialist nurses, service managers, support staff and the senior management team.

During our inspection, we spoke to over 50 patients, carers and relatives. We visited a number of the clinics and care homes where district nurses were providing care and we accompanied district nurses to a small number of people's homes to talk with patients and their relatives about their experiences. We also used information provided by the trust and information that we requested. To inform our inspection we also looked at paper and electronic medical records in all of the areas we visited.

Summary of findings

What people who use the provider say

People who used services said that staff treated them with dignity and respect. The multidisciplinary team communicated well with each other and worked well together. They told us that staff were compassionate and caring.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should improve the processes for reporting and learning from incidents, accidents and near misses.
- The trust should review records management to minimise duplication and the risk of transcription errors.
- The trust should ensure there is a robust, embedded system to determine appropriate staffing and caseload size.
- The trust should ensure that the completion of mandatory training and personal appraisal and development reviews (PADR) are consistent across the teams and are meeting trust targets.
- The trust should ensure that referral to treatment times meet agreed targets, in particular for podiatry services, pulmonary rehabilitation and community nursing.
- The service should improve the processes for conducting audits and for sharing any feedback gained from these.

Humber NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

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

Are services safe?

By safe, we mean that people are protected from abuse

Summary

An electronic incident reporting system was in place, however staff's understanding and reporting of incidents was inconsistent across the teams. We were not assured that all incidents were reported appropriately.

We found hygiene and cleanliness, the environment and equipment were well managed.

There were three systems used to record patient information. There was duplication and a risk of transcription errors. We found that in records reviewed, information had not been fully transcribed and found transcription errors in some records.

Staffing and caseloads varied across the teams. There was no robust, embedded system to determining appropriate staffing and caseload size, particularly for community nurses.

Detailed findings

Incidents, reporting and learning

There were 517 incidents reported from community nursing between February 2013 and January 2014. Of these 381 were regarding pressure ulcers.

An electronic incident reporting system had been implemented and most staff we spoke with knew how to report incidents. Staff's understanding of what to report as an incident was varied. Some therapists and staff in the Goole neighbourhood care team told us they might not report an incident if it could be handled by them without management support. All staff we spoke with said they reported clinical incidents, such as pressure ulcers and falls. This was reflected in the trusts incident reports. We were not assured that all incidents were reported appropriately.

Incident reporting was discussed at staff meetings and staff received communications from an organisational level such as the weekly newsletter, the Blue Light Alerts (high

level incident reports) which supported learning from incidents. However, there was a lack of feedback about the outcomes of incident investigations to the individual staff who had reported the incident.

Cleanliness, infection control and hygiene

Staff were aware of infection prevention and control guidelines. We observed staff washing hands and using hand gel following care, following the 'bare below the elbow' guidance and wearing personal protective equipment, such as gloves and aprons, whilst delivering care. Infection prevention and control link nurses were assigned in each locality to inform staff of any updates to practice or procedures.

Generally, equipment was cleaned and protocols were available, but we noted there were no current cleaning protocols or regular cleaning for spirometer turbines (used to measure lung capacity and air flow). Although national guidance and best practice was not being met, the potential risk to patients was small due to other elements of the policy, such as using one way disposable mouthpieces.

Maintenance of environment and equipment

Staff confirmed they had access to sufficient supplies of suitable equipment. Where appropriate, single use equipment was used across all service environments, including the patients' homes, and disposed in accordance with instructions.

Some equipment was available on-site, for example, the falls service had a store of Zimmer frames. Staff could order larger items of equipment, such as wheelchairs, mattresses and frames, from the central stores which were managed by an external organisation.

Equipment was calibrated according to schedules. For example, we saw the bladder scanner was calibrated yearly and we viewed the spirometry calibration log which had evidence of regular checks.

Medicines

The trust employed independent prescribers. We spoke with an independent prescriber and found they prescribed according to their areas of competence, gained appropriate consent and described to the patient side effects or risks of medication before any medication was prescribed. We also saw use of the "Fullers" self-medication risk tool for patients who could manage their own medicines.

The trust had introduced an online prescription ordering service (ONPoS) which enabled effective ordering and stock control of wound management products from an agreed formulary and was easily accessible to community nurses.

Safeguarding

Safeguarding policies and procedures were available and were displayed in offices and on notice boards throughout the services. Trust-wide data showed 79% against a target of 80% of staff had received mandatory training in safeguarding children and vulnerable adults. The trust didn't collate summary information for community staff at the time of inspection.

Staff we spoke with demonstrated an understanding about safeguarding procedures. There were safeguarding link nurses and a safeguarding lead for the division. Safeguarding issues were discussed during individual staff supervisions and during group clinical supervision meetings.

Where "best interest meetings" had taken place, information was recorded in the electronic recording system and copies were also kept in patient's notes in their home.

Deprivation of Liberty safeguards

The Mental Capacity Act 2005 was adhered to in the cases we reviewed and deprivation of liberty safeguarding was applied appropriately.

Records

The trust operated three different record-keeping systems. The electronic recording systems (SystmOne) ensured records were managed securely. Staff completed standard templates according to the pathway or therapy patients were following. We looked at 20 electronic patient records and these were up to date and accurately completed. Records included a comprehensive assessment process. The templates in SystmOne contained information about referral, triage, admission to caseload, appointments, consent forms and care plans. Observations were recorded; the timing of such was dependent on the acuity of the patient. Staff could easily locate and obtain any additional notes we required when conducting our patient record review.

Templates within SystmOne had not been set up for all the specialities, such as the speech and language therapy (SALT) team, which meant they continued to maintain paper records which could not be accessed across other specialities.

Patients had hard copy paper records in their home which were collected and archived at the end of an episode of care. Although SystmOne was enabled on specific laptops, poor connectivity of the laptops to an internet signal meant community staff recorded information in the patient held records, their own paper records and then transferred the information into SystmOne when back at the office base. This meant a duplication of effort and a risk of transcription errors when staff updated the electronic record. We looked at four sets of paper notes from home visits in the Beverley team which had been entered electronically. We found the information had not been fully transcribed and there were transcription errors in two of the records.

In addition, SystmOne could not link in with Lorenzo (used by the mental health community teams to track and record patient information). This meant that joint visits took additional time as additional paperwork had to be printed. The general managers told us they were working on a solution to create a patch to link both systems together.

Lone and remote working

Staff followed policies and procedures to ensure safety when working alone out in the community. Assessments were conducted to ensure risk factors such as environmental, physical and patient related were documented and inputted into the patient records so staff knew what to expect and could take the relevant precautions. Staff were issued with mobiles phones, had 'safe' words and worked in pairs when risks were identified. Arrangements were also in place for lone and remote working at weekends and out of hours.

Assessing and responding to patient risk

Nurses completed risk assessments such as falls and nutrition in patient's homes as part of an initial assessment. We saw specialist teams had specific risk assessments which were completed. We observed nurses explain risks to patients, for example, the risk of falls. We saw good practice where services worked together to minimise risk for a patient who was smoking whilst on oxygen therapy.

A nurse practitioner role was in place to support patients who were elderly or had serious illnesses such as heart problems or diabetes and were frequently admitted to the emergency department. Risk and relapse plans were in place for patients whose condition may deteriorate and a named contact was provided for the patients.

Staffing levels and caseloads

Staffing levels varied across the teams and localities. There was no systematic approach to determining appropriate staffing and caseload size, particularly for community nurses. One district nurse explained that she was conducting 15 to 20 visits a day and was waiting for new staff to complete training so this may decrease. Another community matron "struggled" to cover an area of five GP practices with a caseload of over 100 patients. Two cardiac specialist nurses told us they managed 106 patients between them and often worked through their lunch break and often finished late.

The trust had recognised and recorded on the risk register, the increased demand and complexity of patient care within the neighbourhood care services which affected the delivery of timely, effective and safe care. Staff were working with an increased numbers of visits and the trust had worked with commissioners to secure temporary funding for 20 community nursing posts. This had improved the staffing across the nursing teams, but was a slow process. It was unclear if the additional funding would continue.

An out of hours nursing service began at 17:30 to 23:00pm with four teams who provided care across the East Riding of Yorkshire. Staff told us they did not always have four teams due to staffing shortages. On the evening we visited the service, we found that there were two instead of four teams that evening. Staff reported that they had managed the workload on this occasion but there was no capacity for additional or urgent referrals. This information was not reported or recorded by the trust.

Therapist staff such as physiotherapists, occupational therapists and podiatrists told us they were routinely understaffed and not meeting capacity and demand. The therapy teams were staffed to meet commissioned establishment. At the time of the inspection all of the vacancies except one were filled with locums to ensure

continuity of service. Staff told us that it was difficult to recruit suitable staff. This was confirmed by managers who said there was a shortage of suitable staff within the geographical area.

Major incident awareness and training

A business continuity plan listed the key risks that could affect the provision of care and treatment provided by the trust. There were clear instructions in place for staff to follow in the event of major incidents such as snow, floods or staff shortages. Staff were aware of major incident plans and described the action they would take.

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

Staff had access to evidence-based guidance and we saw this was followed in practice.

There was limited participation in clinical audit. The trust's clinical annual audit plan for 2013/14 detailed no audits for community nursing with the exception of the trust's record-keeping audit. Therapy staff in East Yorkshire told us they did not have time to conduct any audit activities.

Staff were competent and worked well in multidisciplinary (MDT) teams. We saw evidence of coordinated integrated care pathways, in particular mental health services and telemedicine services were provided by the Community Services team in partnership with Hull and East Yorkshire Hospitals NHS Trust.

Detailed findings

Evidence based care and treatment

Staff had access to evidence based guidance. We saw different specialist nursing competences and observed care being offered following national guidance. This included guidance from National Institute for Health and Clinical Excellence (NICE), British Thoracic Society (BTS), European Respiratory Society, British Dietetic Association, as well as Department of Health evidence papers on good practice.

Templates and care plans on SystmOne were validated and linked to evidence bases such as the Marsden Manual (a practice based tool by The Royal Marsden Hospital Manual of Clinical Nursing Procedures).

We saw evidence of active involvement of staff in discussions around using the national guidance. For example, the bladder and bowel specialist team told us they discussed tools at their clinical meetings and the lead tissue viability nurse evidenced best practice through networking and publishing work in national journals.

Pain relief

During home visits we observed staff responded promptly to patients expressing need for pain relief.

Nutrition and hydration

Patient records included an assessment of patients' nutritional requirements. Where patients had a poor nutritional intake, they were risk assessed and fluid and nutrition charts were put in place to ensure they received adequate food and drink. Where necessary, a dietetic assessment was performed.

A service had been established to support patients who were identified as elderly or had serious illnesses such as heart problems or diabetes. This team provided education, Met Office alerts and support, to care homes during periods of hot weather. The met Office share knowledge and advice about how the weather and climate will affect them. This knowledge can help care staff make informed decisions on whether they need to provide additional care, especially to the vulnerable population.

Patient outcomes

Patients and relatives we spoke with were positive about the care and treatment they received, however there was limited benchmarking of patient outcomes.

The trust's clinical annual audit plan for 2013/14 detailed no audits for community nursing with the exception of the trust's record-keeping audit. However, they did monitor some outcomes through the patient safety thermometer. This showed the percentage of the trust's patients with new pressure ulcers fluctuated over the year and for some periods they were significantly above the England average. The percentage of the trust's patients with new VTEs (Venous thromboembolism) had been above the England average for the last 12 months. The percentage of the trust's patients suffering falls with harm were above the England average for a large proportion of the year, for community district nursing. We found that although there were peaks across the year, the overall numbers for pressure ulcer prevalence, falls and venous thrombo-embolism was low and had been reviewed and understood by the trust.

Therapy staff in East Yorkshire told us they did not have time to conduct any audit activities. The nutrition and

dietetics team staff in Hull told us they had audited record keeping, the environment and the new nutrition policy where they audited the standards of dietary information leaflets.

We found the falls team had monitored patient outcomes and identified an increase in patient confidence and decreased fear of their falling.

Performance information
The service managers and matrons received monthly performance reports which were reviewed to identify changes to areas such as patient demand and staff sickness levels. Performance data showed that referrals to neighbourhood care teams had increased overall from 6% in Driffield to a 9% increase in North Holderness for the year to date. However, this information was not readily available or accessible by all service managers that we spoke with.

We saw a quarterly trust report which contained an overview of serious incidents from 2011 to date and provided a breakdown of the incident type and location over a period of time. We saw these were themed by location in order to gain an understanding of issues.

The nurses told us they did a high number of telephone contacts with patients and other professionals relating to their care. However, the system and performance reports showed comparatively low numbers of this activity and an overall decrease. The data was dependent on staff accurately recording the information onto SystmOne. Staff were not confident in the accuracy of the information for data reporting.

Competent staff
Newly appointed staff underwent an induction process that lasted up to six weeks. Staff told us the induction process was effective and they received good support from their peers and line managers.

A competency framework for nurse practitioners and healthcare support workers had been recently reviewed and updated. We saw competency based training around wound management. The trust had invested in staff training and 95.4% of qualified general nurses had attended a four day course and healthcare support workers attended a two day course.

The staff across the community and inpatient ward teams, told us they received training through a variety of sources, including professional qualifications and in-house training.

Managers received regular risk rated electronic reports on staff training to ensure all staff had attended. Staff kept their own records of training and booked themselves on training when needed.

Trust data showed that completion of mandatory training and personal appraisal and development review (PADR) was not consistent across the teams. The trust target was 75% for mandatory training compliance and 85% for PADR completion. Although some teams had achieved these targets, four neighbourhood care (community nursing) teams did not achieve these targets. For example, the Driffield neighbourhood care team had only completed 57.1% of PADR's and 69.3% of mandatory training.

Use of equipment and facilities
Specialist staff had appropriate equipment to support all aspects of their visits. We saw staff used the equipment appropriately and educated patients regarding its use.

Equipment was readily available for the majority of patients.

Telemedicine
A self-referral and advice service was provided by the community services team in partnership with the local acute trust. "PhysioHull Direct" provided a triage, assessment and treatment service for patients over 16 who had aches, pains or stiffness in their joints or muscles. Patients with musculo-skeletal conditions called in and were either triaged over the phone and provided information relating to their condition or could access services in a number of locations across the city of Hull. Evening and Saturday morning clinics were available.

Multidisciplinary working and working with others
Our observations of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. We observed a meeting at the integrated stroke service and found very effective interaction between the internal and external services which included social services and commissioners. Patients were placed at the centre of their care and teams worked together well to deliver a good quality of care. This included provision of joint appointments for patients with a range of staff involved with their care which was more convenient for the patient.

Are services effective?

Teams linked with external specialities such as the palliative care service, hospices, GP's falls services and the fire service. The community nurses held weekly meetings to provide a handover of patients with higher needs to specialist staff such as the nutrition and dietetics team.

The PhysioHull service's multidisciplinary team included local consultants in orthopaedics, rheumatology, neurosurgery and pain and therapy staff including physiotherapists, osteopaths and podiatrists. They were part of the clinical networks and had partnerships with the local authority and voluntary services. Within the service GPs, consultants and therapists worked as a single team, helping patients with musculo-skeletal conditions to recover safely and quickly in the community. This meant the team could communicate quickly and easily between departments and work together to manage patients with more complex conditions.

Coordinated integrated care pathways

Coordinated integrated care pathways were seen throughout the services, in particular when community services linked in with the mental health services.

Specialist nurses were empowered to deliver proactive care and described clear care pathways. Staff told us generally there were clear referral criteria. For example, the falls team had a programme approach with four pathways dependent on the needs of the patients.

Are services caring?

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

Summary

Staff treated patients with dignity, compassion and respect. Patients and their carers and families spoke positively about the care and treatment they received. They also felt involved in their care and supported with their emotional needs.

We found limited information for patients and relatives about bereavement and counselling services. However, the trust was in the process addressing this.

Detailed findings

Compassionate care

Staff were observed to be compassionate, understanding and patient centred. They were sensitive to the needs of vulnerable patients and to patients physical health needs. The majority of patients and relatives we spoke with were positive about the care and treatment they received based on their individual needs.

Dignity and respect

Staff treated patients and their relatives with dignity and respect when attending to care needs or whilst performing assessments. Staff greeted patients in a professional and friendly manner and used the patient's preferred name. A carer said, “Staff are so patient with everybody”.

We observed positive interactions between staff, patients and their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care and treatment being delivered. We saw privacy and dignity maintained in the clinic and at home.

Patient understanding and involvement

Patients and their representatives were involved in care planning and had signed to say they had understood the care plans. Clear explanations were offered by staff with understanding demonstrated by observation and patient feedback during home visits.

Emotional support

Staff understood the importance of providing patients with emotional support. We observed positive interactions between staff and patients whereby staff provided reassurance and comfort to people who were anxious or worried.

Patients and their representatives told us they were supported emotionally, particularly when they received a new diagnosis or their condition changed. We observed this during home visits where emotional support was integrated with other aspects of care we directly observed.

The trust has a lead nurse consultant for end of life care whose role included bereavement counselling. All district nurses undertook bereavement visits and patients were signposted to other trust services should they require it. The trust was in the process of appointing a bereavement lead that could provide additional support and advice for staff.

Promotion of self-care

The district nurses team told us they worked to prevent hospital admissions for patients with long term conditions and our observation of practice and discussions with patients and their relatives confirmed this. For example, the falls team promoted self-care and supported patients with self-management via a 16 week care plan that focused on patients becoming independent. We saw clear evidence of setting and addressing patient goals as part of home visits.

Are services responsive to people's needs?

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

Summary

Referral to treatment times for podiatry in Hull and the East Riding of Yorkshire pulmonary rehabilitation service was 80 weeks and 19 weeks respectively against targets of 18 and 10 weeks. Service specifications were not in place for some services such as the occupational therapy and the speech and language therapy service. This meant staff were not clear about the service they should be providing in their areas.

Some community nursing teams were below the 100% target for the proportion of preventable or urgent referrals seen within four hours. Some teams were not meeting the targets regarding initial and follow-up visits to patients.

Staff adopted a flexible approach to the delivery of care to patients, who could be referred to the services in a variety of ways. There were systems in place to support vulnerable patients.

Complaints were managed effectively, but feedback was not consistently shared to help staff learn from them.

Detailed findings

Staff described how they would allow for caseload prioritisation according to the acuity of their patients. The electronic record management system could prioritise patients and visits according to those who needed a visit and those who could wait depending on risk.

Service planning and delivery to meet the needs of different people

We were informed there were strong relationships with commissioners within some services such as the level 3 falls team (whole system MDT approach). However there was a lack of agreed service specifications for some services, such as the occupational therapy and the speech and language therapy service. This meant staff were not clear about the service they should be providing. The general manager told us they were working with commissioners to agree service specifications and were streamlining contracts.

Access to care as close to home as possible

Staff and patients confirmed that services and treatments were planned as close to home as possible and that these were always informed by the views and wishes of the patient. For example, staff in the pulmonary rehabilitation team ran simultaneous clinics in different local venues to address geographically disperse areas. Staff in the bladder and bowel specialist team said "patients have a choice of which clinic they want to attend and they can be fitted in by adding extra clinics if we need to". PhysioHull Direct provided services in a number of locations across the city of Hull with evening and Saturday morning clinics as required.

Where patients were unable to attend any clinics due to ill health, staff made appointments and visited patients at home to ensure they were treated.

Access to the right care at the right time

Patients were referred to the services through a number of routes including their GP, consultant, or they could sometimes self-refer, for example via the Physio Hull services.

Referral to treatment times for podiatry in Hull and the East Riding of Yorkshire pulmonary rehabilitation service was 80 weeks and 19 weeks respectively against targets of 18 and 10 weeks. The service manager advised that the delays for podiatry were being addressed. Most community services, particularly in the East Riding of Yorkshire, did not have targets set by the commissioners and was not monitored.

For community nursing, performance reports for Beverley, Bridlington, Driffield and North Holderness areas showed they were below the 100% target for the proportion of preventable or urgent referrals seen within four hours. These are short notice referrals where an urgent response by a community clinician may prevent a hospital admission. In Bridlington the target was achieved in 45% of cases with a stable trend for March 2014 and in North Holderness it was at 54.5% with a worsening trend. The other two areas were showing improvement.

The trust also had a target to triage and contact 100% of new referrals within a day. The performance data up until March 2014 showed that the four teams were mostly able to perform a paper based triage and meet this target e.g. the Driffield team achieved 88% in March 2014. However, all

Are services responsive to people's needs?

four teams were only around 50 to 60% towards meeting the 100% target for contacting and visiting the referred patients which meant increased wait times before patients could be physically seen.

The number of community team open referrals meant teams were not able to meet their follow up face to face contact targets. The Bridlington neighbourhood team had missed the target by 381 patient contacts and in Driffield by 166 contacts in March 2014.The trust had a target to reduce the number of patients requiring face to face visits but had determined visits were necessary to ensure the safety of patients.

A definition of 'house bound' patients had had been agreed with the commissioners. This meant that patients who could attend clinics were being encouraged to whilst those that could not were seen at home. Attendance at wound clinics had increased from 12% to 30% which meant house visits were conducted according to patient need.

The increased workload of the day staff had an impact on responsiveness of the evening out of hours nursing service workload. Performance data in March 2014 showed an increase in referrals of 37% in the year to date from the Beverley team and 56% from North Holderness team. Staff reported that clinical work, unable to be completed by the day staff, was increasingly being passed to the evening service. Staff told us that patients with urgent needs were prioritised. The service manager told us that calls were triaged using clinical decision making to decide if the visit, such as a dressing, could wait until the next day. They also said the service worked closely with GP out of hour's service and visits could be passed to them if needed. No data was available regarding missed or delayed calls.

Single point of access (SPOC) teams were set up to take calls at one location in each locality which meant they could be more responsive by risk assessing patients who needed to be seen first. However, the SPOC team did not cover weekends which made it difficult as staff had to keep going in to check the answer machine. Not all teams, for example, the stroke service, were covered by the SPOC team. This meant patients left messages on individual team member's phones and there could be a delay in responding.

Performance data showed the face to face contacts for the physiotherapy and occupational therapy had increased over the year. In Driffield, first time contacts had increased from 14 patients in April 2013 to 35 in March 2014 and follow up patients seen had increased from 60 to 90 in the same period. This led to longer waiting lists.

Flexible community services

Staff adopted a flexible approach to the delivery of care to patients. Our observations, review of records and discussions with staff confirmed that vulnerability factors and capacity concerns were taken into consideration when planning and delivering care to patients in their own homes.

Patients were offered choices of appointments times and, on some occasions, were able to attend specific clinics.

Meeting the needs of individuals

Support was available for patients with dementia and learning disabilities. There were dementia and learning disability champions and link nurses within the teams. Teams such as the neighbourhood care service and falls service were in place to meet patient needs holistically and in a patient-centred way with set goals.

Staff told us they had difficulty accessing interpretation services although a translation telephone service was available for patients where English was not their first language. A translator would be requested and made available for any procedures requiring consent.

Moving between services

Staff had strong links and liaison with other services and confidence in referral systems to other agencies where they consider patients to require additional support. For example, working with social services to provide support packages to those people assessed as needing additional support packages from the local authority.

We saw evidence of planning to involve other services, for example, we observed staff addressing a falls risk with input from the falls team to allow for community care to be implemented.

Complaints handling (for this service) and learning from feedback

Patient Advice and Liaison Service (PALS) service leaflets and comments boxes were available in the clinics we visited as well as information on how to raise complaints.

Are services responsive to people's needs?

Some teams, for example the nutrition and dietetics team and the bladder and bowel specialist team gave examples of service improvement following patient feedback; other teams were unable to give any examples where patient's views had been utilised to inform service design.

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 of findings

Senior staff clearly expressed the trust's vision and values, and they were positive and proud of the work they did. However, staff at more junior levels were uncertain about the vision and strategy.

There was effective teamwork and visible leadership across most teams apart from therapy staff who felt under-represented at a corporate level.

Systems were in place to disseminate information about quality and risk such as quality circle meetings. Local risk assessments were available and updated.

Staff spoke positively about local leadership of services. Feedback from patients was gained in an ad hoc manner.

We saw examples of innovative work across many teams in the trust.

Our findings

Vision and strategy for this service

The trust vision was clearly expressed by the more senior staff we spoke with. Some staff told us they had attended team building sessions with senior trust members where they had received presentations in regards to the vision and strategy. However, staff at more junior levels, such as Band 3, were uncertain about the vision and strategy.

Individual teams expressed a clear vision and strategy, for example there was a cohesive and clear vision for community respiratory service which was "trying to breathe new life into respiratory patients". The team vision and strategy focused on the whole individual and the vision was to work as one respiratory team. The pulmonary rehabilitation service had a clear holistic vision for their team and an innovative approach to care. They told us they were proud being part of the team; it was the best team they had ever worked in.

The trust had a comprehensive project underway to 'transform community services' which included clear objectives relating to patient safety and providing effective care. There were a number of work streams in place to look at areas such as 24 hour working, clinical systems, skill mix and care management of adults with long term conditions.

Staff were positive about the transformation change programme and were signed up to visions at every level. They were moving towards neighbourhood teams with a philosophy of one person - one plan. Staff told us most staff had embraced the change.

The therapy staff felt they were underrepresented at a higher level especially with the lack of performance targets. Some staff told us they felt the services were set up to fail and they were always firefighting. The general managers for community services told us they were aware of this issue and were working to ensure the services were represented at all levels by working towards setting up service specifications with the commissioners.

Guidance, risk management and quality measurement

Systems were in place to disseminate information about quality and risk such as quality circle meetings. Local risk assessments were available in the locations we visited and staff were aware of these. The risk assessments were updated on an annual basis. Staff had an awareness of risk management and told us "risk management is getting there".

Staff performance was reviewed and teams received monthly performance reports, which included information data for patient flow, financial performance and staff training and sickness. However, this information was not always disseminated to staff at all grades.

Leadership of this service

Staff were aware of the executive team who had visited some services and had involvement in the transformation work. However, many staff told us they had not met the chief executive and were concerned that there were so many changes within the executive team in a short space of time.

Staff spoke positively about local leadership of services and staff respected management. Staff in the pulmonary rehabilitation focus group told us they had good leadership and responsiveness from their team leader. They told us

Are services well-led?

there were improvements in team cohesion particularly during recent months. Neighbourhood care teams told us they had aligned with one general manager which had "helped enormously".

Therapist staff did not feel supported or engaged with the provider. They felt there was a lack of planning in the services with additional staffing resources being put into nursing care rather than therapy services.

The trust was aware their top reason for sickness absence was stress, which resulted in 27 employees being absent at any time during the quarter. The trust had conducted surveys and had referred staff to occupational health. Overall absence due to sickness was higher than expected in some teams. For example, in the Beverley neighbourhood care team 13.9% of calendar days had been lost due to sickness in the year to date.

Culture within this service

Overall, staff were positive and proud of the work they did and felt supported. They reported an open culture and felt managers listened and reacted to their needs. We observed that staff from all specialities worked well together and had mutual respect for each other's specialities.

Staff told us they felt respected and working within their teams felt like "being with family". However, some staff struggled to accommodate different ways of working within the organisation since the merger between the mental health and community services providers. Some staff still felt that the organisation was being led by the staff from the predecessor organisation.

Public and staff engagement

Service user feedback was collected systematically. Not all the services conducted patient feedback and staff could not describe feedback from users. Staff told us the "friends and family test" was due to be initiated, however, were not involved in the process.

Individual team feedback was gained in an ad hoc manner by several teams. The pulmonary rehabilitation team used the Bristol COPD Knowledge Questionnaire after patient discharge. Staff told us feedback from the satisfaction questionnaires and comment cards were universally positive, other than patients asking for more service.

We saw the bladder and bowel service patient satisfaction documents and patient assessment leaflet as well as a copy of their customer satisfaction survey but there was no overall summarised version since 2009. The nutrition and dietetics team staff told us no recent patient satisfaction surveys were conducted and some clinical areas felt unsupported, such as the eating disorders and re-feeding syndrome team.

Staff received communications from an organisational level such as the weekly newsletter, the Blue Light Alerts (high level incident reports) and attended team meetings. Overall staff felt they were listened to and felt supported, however, the inconsistency and variability in practice in regards to communication with staff, meant that some staff did not feel well engaged with senior managers within the organisation.

Innovation

Evidence of innovative practice was apparent across different teams. This included the respiratory team having won trust wide staff awards for the past two years for their holistic approach to patient care and the falls team changing their approach to their service and its funding. The stroke rehabilitation team in Hull had worked to create activity groups for patients such as walking, fishing and knitting so they could bond and share experiences in a non-therapy environment.

The pulmonary rehabilitation team had designed documents for patients about the scope of services and how patients could link in with other services entitled "It's not just about the lungs" and "Breathing new life into respiratory patients".

An example of services and processes being developed to maximise efficiency of resources was seen in the START back programme (Physiotherapy service for chronic back pain). Another example was that a 'virtual clinic' for tissue viability had been introduced via SystmOne where a photo of the wound (with patient's consent) was shared securely for specialist clinical advice which was recorded in the patient record.

These services were supported by the trust and commissioners and had the backing of staff.

Improvement and sustainability

The trust had a comprehensive project underway to 'transform community services' which included clear objectives relating to patient safety and providing effective care. Staff were positive about the transformation change programme and were signed up to visions at every level.