

South West Yorkshire Partnership NHS Foundation Trust

RXG

Community health services for adults

Quality Report

Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP
Tel: 01924 327000
Website: <http://www.southwestyorkshire.nhs.uk>

Date of inspection visit: 07-11 March 2016
Date of publication: 24/06/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXG10	Fieldhead Hospital		WF1 3SP
RXG82	Kendray Hospital		S70 3RD
RXGX5	Mount Vernon Hospital		S70 4DP

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

Summary of findings

Ratings

Overall rating for the service		Good	●
Are services safe?		Good	●
Are services effective?		Good	●
Are services caring?		Good	●
Are services responsive?		Good	●
Are services well-led?		Good	●

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the provider say	7
Good practice	7
Areas for improvement	7

Detailed findings from this inspection

The five questions we ask about core services and what we found	9
---	---

Summary of findings

Overall summary

We rated this core service as good because:

- Systems to manage and report incidents were in place, safeguarding procedures were robust and records were up to date.
- Medicines were stored and administered appropriately. Equipment was readily available and cleanliness and infection control procedures were followed.
- Risks to the delivery of care for patients were managed and action taken to mitigate them.
- Services were mainly fully staffed, mandatory training was up to date and staff development was supported.
- Care and treatment followed evidence based guidance.
- Care pathways were coordinated, multidisciplinary working was effective and outcomes for patients were evidenced and audited.
- Patient's consent to care and treatment was documented.
- Care was delivered with compassion and staff treated patients with dignity and respect. Patients were involved in decisions about their care and treatment and received emotional support.
- Community services had a clear vision focussed on the patient at the centre and the needs of patients influenced the planning and delivery of services, including care for patients with diverse cultural needs.
- Patients had timely access to services, with minimal waits for most services. Few complaints were received by the service.
- Governance arrangements supported the delivery of care for patients. Performance measures were used which were monitored and action was taken when issues were identified.
- The service demonstrated a positive, focussed culture.
- Community services operated in an environment that encouraged improvement and innovation.

Summary of findings

Background to the service

South West Yorkshire Partnership NHS Foundation Trust provides services across Barnsley, Calderdale, Kirklees and Wakefield to a population of over one million people. The trust provides inpatient, community and day clinics as well as specialist services within West Yorkshire, and also to a wider geographical area for some of their specialist services.

Services for adults within the community included district nursing, therapy services, specialist and community nursing, rehabilitation and telemedicine. Rapid response

provided out of hours care to patients using the district nursing service. The hospital at home service provided a rehabilitation service in patients' own homes and in residential care.

Community services for adults employed 382 full time equivalent staff, with the largest service being district nursing with 107.7. The service received referrals from patients, GPs, other healthcare providers and social services and the trust recorded 600,000 community contacts in the year 2014/2015.

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

Our inspection team

Our inspection team was led by:

Chair: Peter Jarrett, Retired Medical Director

Head of Hospital Inspection: Jenny Wilkes, CQC

Team Leaders: Chris Watson, Inspection Manager, mental health services, CQC; Berry Rose, Inspection Manager, community health services, CQC

The team that inspected community adults services included CQC inspectors and community nursing and therapist specialists.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive inspection programme.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Prior to the inspection we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning group, Health Education England, the General Medical Council, Local Authorities and local Healthwatch organisations. During the inspection visit, the inspection team spoke with 21 patients, 7 relatives and 121 members of staff, 48 of whom were in focus groups. We observed care being delivered in community locations and in patient's homes. We looked at 28 sets of patient documentation such as care records and risk assessments. We observed nursing

Summary of findings

handovers and multidisciplinary meetings. We reviewed staff records and trust policies. We also reviewed

performance information from, and about, the service. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

What people who use the provider say

Patients and their relatives and carers spoke very positively and expressed their appreciation as to the quality of care they received. The results of the most

recent monthly NHS Friends and Family test for community health showed that for 703 responders, 82% of these were extremely likely to recommend the service as a place to receive care.

Good practice

- The service had developed a drop-in mobility clinic for patients with mobility and falls issues. The clinic had been extended to cope with increased demand. Patients attending were screened for falls and follow up assessments were arranged if required.
- The care navigation / tele health service linked with other community services in promoting patient self-management of long term conditions. The care navigation service provided signposting, referral, advice and support for patients following a crisis. The service provided ongoing coaching and support to promote self-management for patients with long term conditions. Health coaching was linked, for example, to weight management. The service could demonstrate its effectiveness in preventing hospital admissions.
- The stop smoking service offered access via both telephone and instant messaging support. It had also developed an online portal where patients could register and undertake their own stop smoking journey.
- The tissue viability service managed the incidence of pressure ulcers proactively and it had developed an action plan for 2016/2017 in response to the incidence of pressure ulcers. The action plan included identifying care homes with an increased risk of pressure sores and delivering training to identified care homes as a pilot of the “React to red” skin initiative. The tissue viability service used a wound care formulary and followed agreed protocols.
- The adult epilepsy service had well developed links with the emergency department of the local hospital and held a weekly referral meeting to review emergency admissions. The service maintained similar links with the ambulance service to review patients with an established diagnosis of epilepsy. The adult epilepsy service provided a series of two to three education and guidance sessions to inform patients and their carers in residential care homes.

Areas for improvement

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

Action the provider **SHOULD** take to improve

- The trust should ensure that lines of accountability to the senior management team are clear to staff in front line community services.
- The trust should ensure that community services staff are fully engaged and consulted as to the transformation of community services.
- The trust should ensure community clinics provided by the district nursing service are reviewed in liaison with practice nursing provided by primary care to ensure community nursing consistently prioritises housebound patients.

Summary of findings

- The trust should ensure that the podiatry service is staffed to planned establishment levels.
- The trust should ensure the staff intranet and trust internet reflect the full range of community services available for patients.
- The trust should ensure that Patient Group Directions are up to date.
- The trust should ensure that the policy for lone working is up to date.
- The trust should ensure arrangements to record clinical supervision are in place.

South West Yorkshire Partnership NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Systems to manage and report incidents were in place and staff knew how to use these appropriately. Lessons learned from the investigation of incidents were fed back to staff through team meetings and other communications and practice coaches were used to support learning. Processes complied with duty of candour guidance.
- Safeguarding policies and procedures were robust and staff followed procedures when safeguarding risks were identified. Safeguarding referrals were straightforward to complete and staff received feedback on referrals. Staff had received safeguarding training.
- Both electronic and manual records were up to date, and included narrative contributed by the multi-disciplinary team. Records were completed appropriately and included detailed descriptions of interactions with patients. Annual audits of patient records took place.
- Medicines were stored and administered appropriately. Non-qualified staff administering medicines followed an extended skills competency framework supported by observation of their practice and annual updates.
- Cleanliness and infection control procedures were followed in all settings including the patient's home. Equipment was readily available and was cleaned, maintained and replaced appropriately.
- Escalation pathways were in place for assessing and responding to patient risk and staff followed the correct pathways.
- Each service (with the exception of podiatry) was staffed to planned establishment levels and staff mainly handled a suitable caseload of patients. Staff in the district nursing service were assigned to visits on a daily basis, according to the needs of patients.
- Mandatory training was completed and up to date. Training compliance was evidenced both locally and across the service. The average mandatory training rate for the community adults' service was 90%.

Are services safe?

- As part of the “React to Red” pilot supported by NHS England, the tissue viability service had developed an action plan for 2016/2017 which included identifying care homes with an increased risk of pressure sores and delivering training to identified care homes.

However:

- Although the trust had a policy in place for lone working which was followed by staff when visiting patients, the policy was out of date at the time of our inspection and had been due for review in January 2016.
- Although Patient Group Directions (PGDs) were in use and sign off was audited, some PGD’s were outside of their review period.

Detailed findings

Safety performance

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and harm-free care. The improvement tool focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- The service used the NHS Safety Thermometer to measure harm free care delivered to patients. The service completed the Safety Thermometer monthly. For example, the hospital at home team recorded 100% harm free care of patients between February 2015 and the time of our inspection. The district nursing service had recorded 97.5% harm free care in this period.

Incident reporting, learning and improvement

- Services for community adults reported 908 incidents between November 2014 and October 2015. The service recorded patient falls at home in its incident information. The majority of these incidents were recorded as causing no harm to patients.
- The service reported 15 serious incidents between 30 June 2014 and 19 September 2015. Fourteen of these related to category three pressure ulcers and one to a category four pressure ulcer.
- The service reported incidents using an electronic incident-reporting system widely used in the NHS. Staff we spoke with were aware of how to report incidents through the electronic reporting system.

- We reviewed examples of action plans developed in response to reported incidents. We found documented evidence of actions to progress, with timescales for completion, and nominated lead staff. Feedback from the investigation of reported incidents was given to the members of staff concerned immediately, as well as learning being shared in staff meetings and through other forums. The patient safety team produced a leaflet of lessons learned which was distributed to staff.
- Staff were able to provide instances of lessons learned from incidents. For example, training the service provided for staff in residential care homes was amended to reflect their specific needs, and a training video was developed as a result of an incident. Further examples of learning from incidents were the use of key safes at the patient’s home, and ringing the patient ahead of a home visit, so that the member of staff was expected.
- However, some staff told us that although they received feedback from the investigation of incidents they reported, usually by email, they felt this was inconsistent and that feedback was not always provided.
- The results from the NHS Staff Survey 2015 showed that the trust performed worse than the national average for the fairness and effectiveness of procedures for reporting errors, near misses, and staff confidence and security in reporting unsafe clinical practice. The survey data was not available specifically for this service.

Duty of Candour

- The duty of candour statutory requirement was introduced in 2014 and applied to all NHS trusts. The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or significant harm. The trust had a policy in place relating to this requirement.
- We found staff followed the duty of candour requirements in actioning reported incidents. A duty of candour flowchart was available to staff to provide quick guidance on the requirements when incidents were reported. Staff within the community nursing service explained that this process was embedded within the risk reporting system, with the need to consider duty of candour a specific part of the electronic reporting template.

Are services safe?

Safeguarding

- The trust had an up to date policy in place to provide staff with guidance about safeguarding procedures. This included contact details for staff to use when they identified concerns which required escalation. Information about safeguarding adults and other relevant details about raising an alert were displayed in the centres we visited.
- Between 1 January and 31 December 2015 one safeguarding concern was reported linked to the Kendray Hospital site. No safeguarding alerts were reported.
- Staff told us they found it was straightforward to raise issues with the adult safeguarding team. Staff were confident in being able to access support when they needed to escalate a safeguarding concern. Staff were able to describe their response to two recent safeguarding incidents and to provide examples of their response to safeguarding incidents which occurred in the previous three years. Staff received feedback following safeguarding referrals.
- A separate policy and guidance were available to support responses to instances of domestic violence. The policy included reference to forced marriage, honour based violence, and female genital mutilation (FGM). Staff we spoke with in the health intervention team explained that FGM considerations formed part of the screening assessment for the service.
- Data provided by the trust showed that 92.7% of staff had completed safeguarding adults' Level one training and 87.8% had completed safeguarding adults Level two training. In addition, 84.6% of identified staff had completed safeguarding children Level one training and 85.1% had completed safeguarding children Level two training. Staff we spoke with confirmed that their safeguarding training was mandatory and was up to date.

Medicines

- We found that suitable arrangements were in place for assessing patients' medicines needs on admission, and for recording medicines administration. Medicines needs assessment documentation was completed.
- A standard protocol was used to assess the patient's level of support with medicines. The assessment of

medicines was completed by a qualified nurse.

Administration of medicines was recorded using a community medicines administration chart, with a tear-off portion shared with the patient's GP.

- Where support was provided with medication the service used standard electronic medication related care plan templates that included task lists, to help ensure a consistent approach to medicines handling and recording. These were personalised to reflect individual patient needs.
- Medicines were administered by nurses or suitably qualified healthcare assistants. Out of hours care to patients included a home intravenous service. Policies and protocols were in place for the home intravenous service which was managed in collaboration with a neighbouring trust.
- We observed that the discussion of care arrangements during handover between community nursing teams included consideration of medicines arrangements for patients that may present particular risks, for example patients with diabetes. A medicines management steering group was in place which worked in liaison with the tele health service and GP practices to support management of medicines in primary care.
- Patient Group Directions (PGDs) were in use across trust sites. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. Data provided by the trust confirmed that a number of services, including district nursing, occupational health and the musculoskeletal service were using PGDs.
- Community and specialist nursing staff and non-medical prescribers worked to competency frameworks for their role. Medicines training for qualified staff was refreshed every three years. Unqualified staff who undertook visits to patients, completed medication training appropriate to their role, which was updated annually. Training packages included protocols for handling medication.
- We found that five of the 18 PGD's were outside of their review period. Of the five which required review, two related to PGDs updated by NHS England. The remaining three PGDs that were out of date related to injectable medicines provided by one service. The trust provided evidence of audit of PGD sign off. This identified that PGDs were appropriately signed off and recorded within the services. However, the audit did not

Are services safe?

identify that PGDs in use in one service were overdue for review. This meant that there was a risk of staff providing medications to patients based on out of date authorities and which may not have contained up to date medicines guidance.

Environment and equipment

- In the Patient Led Assessment of the Care Environment (PLACE) 2015 results, both the trust wide and location level scores were above the average for all NHS trusts with regards to cleanliness, food, privacy, dignity and wellbeing, condition appearance and maintenance and dementia.
- We found that arrangements were in place to ensure the safety of equipment. Maintenance of equipment, for example defibrillation equipment, was undertaken by an external organisation. We reviewed items of equipment in each service we visited and found the equipment was checked and maintained appropriately. Equipment was marked with a sticker to indicate when it was checked and when it was due for renewal.
- Equipment to support patients using the tele health service was provided by a specialist external organisation which trained and supported patients in the use of equipment in their own home.
- Equipment for patients' use was supplied promptly. Community and specialist nursing staff told us they could readily access specialist patient aids from the trust equipment service, such as pressure relieving equipment.
- Patients were graded according to need, with "priority one" patients receiving equipment within 24 hours to "priority three" patients receiving equipment within one week. Staff told us that equipment was routinely made available quicker than these timescales. For example, priority one patients usually received equipment on the same day when ordered before 11am. Equipment could be supplied at the weekend in emergency situations.
- We saw that staff within the community nursing service had appropriate mechanisms in place to respond to equipment alerts from the Medicines and Health Regulation Authority. At the time of our inspection, a recent alert had been made in regard to syringe driver pumps. We checked compliance with this alert at a community site and saw that the alert was acted upon and the correct adaptations had been made to syringe drivers. Medical device alerts were shared in team meetings.

- The continence nursing service relied on portable bladder scanners to assist in diagnosis and treatment of continence issues. At the time of our inspection, four of six scanners were not operational. Staff needed to share two scanners between the service. Staff told us that a trial was taking place of three different types of scanners and that a decision would then be made as to which to purchase as replacements for the current scanning units.

Quality of records

- Improving the quality of data was one of the trust's key strategic priorities. The trust informed us there was a continued focus on improving the quality of clinical record keeping.
- Community teams were in the process of trialling the use of laptop computers for each member of staff to support access to systems from flexible workplaces. Specialist nursing staff told us that the evaluation of the flexible working trial was to include an assessment from the patient's point of view.
- Manual records were used to capture information in certain situations, for example in the rehabilitation gym and in the patient's home, where a summary of basic information about the care and treatment of the patient was maintained. For the care navigation and tele health service, patient information was transferred manually from the specialist equipment in the patient's home to the electronic patient record system.
- We reviewed 28 sets of patient records, which represented a sample of the services we visited and included a mix of electronic and paper records. Each record we reviewed was completed appropriately with descriptions of staff interaction with the patient. Care plans and risk assessments were documented using recognised tools to identify particular needs and risks to the patient. Records and assessments were appropriately signed and dated and no issues were identified. Records included outcomes and were compliant with nursing guidance.
- Annual audits of patient records were taking place within the service. For each specialty, another service selected 10 records randomly and checked against key questions, including whether appropriate information was recorded and whether entries were signed, dated and legible. We found that the results of audit were discussed and action plans were monitored.

Are services safe?

Cleanliness, infection control and hygiene

- We observed that community nursing staff were bare below the elbow in clinical areas in accordance with infection control policies. Staff in clinical areas observed appropriate hand hygiene techniques and used personal protective equipment. We observed that community nursing staff carried personal protective equipment and that this was used appropriately when carrying out clinical interventions.
- We observed that hand washing and aseptic non touch technique were followed when accessing venous devices. Clinical waste was disposed of appropriately. Precautions taken to maintain infection control in community settings included identifying patients with a known infection risk, and not carrying used equipment. We were informed that a sharps audit had been undertaken although we did not review the details of this.
- Equipment for use was checked and labelled with an “I am clean” sticker to identify the date it was cleaned and when it required cleaning again.
- Information supplied by the trust showed that as part of mandatory training within the service, 93.3% of staff had undergone training in hand hygiene and 84.3% had completed infection control training.
- Staff confirmed they received training in infection prevention and control and that this was up to date.

Mandatory training

- Information the trust provided showed that 90% of community services staff had completed their mandatory training. Community nursing staff in a focus group and staff individually confirmed that their mandatory training was up to date.
- We reviewed the training statistics available from the staff intranet at community bases we visited, which confirmed that staff mandatory training was up to date.
- Each staff member received an individual training report sent to their work email address and staff received a reminder by email when their training renewal was due.

Assessing and responding to patient risk

- Risk assessments were undertaken in the patient’s home by the community nursing service to determine whether the patient could be maintained at home with support from the service.

- Community nursing patients were risk assessed and allocated a risk grade using a red-amber-green rating system. The patient’s risk rating was determined in accordance with the core nursing assessment and risk ratings within the patient’s care plan. When a patient was identified as having complex needs, they were rated “Red” and assigned to the community matron service to enable access to specialised care.
- We found that specialist and nursing staff were able to describe the escalation procedures which they followed when a patient’s health deteriorated and more specialist intervention was required, for example for patients with diabetes or epilepsy. Acutely unwell patients may be referred to the rapid response service initially.
- The care navigation and tele health service undertook daily vital signs monitoring for their patients, for example those with chronic heart failure or chronic obstructive pulmonary disorder (COPD), using the remote equipment in the patient’s home. If a patient who used the care navigation and tele health service that lived alone, experienced a sudden deterioration, the emergency service was contacted and the patient handed over to the ambulance service. We saw an example of the use of a “Yellow sheet” for patients at risk of hospital admission which was used in liaison with the ambulance service to minimise the risk of the patient’s admission to hospital.
- The tissue viability service managed the incidence of pressure ulcers proactively and it had developed an action plan for 2016/2017 in response to the incidence of pressure ulcers. The action plan included identifying care homes with an increased risk of pressure sores and delivering training to identified care homes as a pilot of the “React to red” skin initiative. The service was developing link champions within care homes and training for the link champions was due to be completed by June 2016. Extending the approach to other disciplines, including mental health, was planned.
- We observed the discussion of care arrangements during handover between community nursing teams. Staff confirmed that clinical handover was used to discuss patients and clinical issues, for example consideration of wound and pressure area care for patients that may present particular risks.

Are services safe?

- Assessment checks undertaken by the heart failure specialist service included identifying the need for flu vaccination. The patient was given a number to call the nursing service and a member of nursing staff was tasked to arrange the vaccination.
- The health integration team had developed an assessment tool to help in identifying the health risks of people seeking asylum. A numerical risk score was calculated to help in identifying patients that required medical intervention.
- Community nursing staff identified some groups of patients, for example those requiring respiratory support, where the review of care arrangements was identified as a priority for the service.
- Where there were identified risks to staff mitigating actions were taken. A local working policy identified a warning system for patients whose behaviour to staff was not acceptable. Where issues were identified staff told us that risk assessments were carried out and two or more staff would attend these locations together. Staff were briefed about what to expect prior to making the visit.
- The trust had a policy in place for lone working. This was out of date at the time of our inspection and had been due for review in January 2016. The policy included guidance on risk assessing visits, requesting colleagues accompany each other if a risk was identified, and the use of a buddy system to notify colleagues of when visits were complete. Staff were aware of the lone working policy and told us that they adhered to this when visiting patients.
- Staff told us that they had been issued with emergency call badges. This was a tool that staff could use to issue an alert if they felt in danger which transmitted their location. Some district nursing staff told us that this did not always work in areas where there was intermittent phone reception. In those areas staff told us that they ensured that their diaries were up to date with the visit schedule and that they would call into base to confirm when appointments had finished.
- At the time of our inspection, there were 6.3 vacancies for qualified nursing staff (with the highest being in district nursing with two) and 2.8 vacancies for nursing assistants (with the highest being in the hospital at home team with 1.8). This equated to a vacancy rate of 3.3% for qualified nursing staff.
- In the twelve months prior to our inspection 45.9 FTE staff had left the service. The highest number of leavers was in the district nursing service, with 9.2 FTE staff. The community nursing service and specialist services we spoke with confirmed they were not carrying vacancies, and staff that left were replaced.
- The average vacancy rate across the service was 7.9%. The highest vacancy rates were in the services with small numbers of WTE staff, such as the diabetes service (one WTE, 71.4% vacancy rate) and the health integration team (2.7 WTE, 64.1% vacancy rate).
- The trust reported no usage of agency staff within community services. The service confirmed that vacant shifts were covered by internal bank staff. In the twelve months prior to our inspection, 2160 hours were covered by bank staff. The highest number of these was in district nursing, with 984 hours covered, including intermediate care.
- The district nursing staff did not carry personalised case loads. Tasks were allocated to staff based on units of work. Visits were allocated to staff on a day to day basis in accordance with demand and staffing levels.
- In January 2016, the district nursing service undertook a capacity and demand review. This identified that the service was making 195,000 contacts per year, with an additional 15,600 above planned levels. This meant that the service projected 210,600 contacts, representing a projected 5.62 FTE additional staffing requirement to meet demand. The trust told us that commissioners were undertaking a community nursing review to address the nursing shortfall.
- Some areas of specialist nursing, for example the adult epilepsy service, operated an inactive caseload from which patients could be referred back to the active caseload if deterioration in their condition required this. Although we found the adult epilepsy service was fully staffed, it was operating over capacity (estimated by the service as up to 40%) to meet the demands on the service. Staff told us that this meant that they were very busy, but that they did not feel it was negatively impacting on patient care at the time of our inspection.

Staffing levels and caseload

- In total, community adult services employed 382.1 full time equivalent (FTE) staff. Of these staff, the service establishment level was 192.9 qualified nurses and 51.41 nursing assistants. The largest staff group was the district nursing service, which employed 107.7 FTE staff.

Are services safe?

- Out of hours cover for community nursing between 5.30pm and 8.30am was provided by the rapid response service.
- The heart failure specialist service arranged cross cover with other teams, including care navigation and the community matron service. We encountered other examples of teams providing cross cover, particularly at weekends.

Managing anticipated risks

- Community services teams managed foreseeable risks and planned for changes in demand due to seasonal fluctuations. Local working instructions were in place for staff in relation to what to do in cases of bad or severe weather. This included contacting case holders, prioritising case loads and relocating to the nearest base location if staff could not reach their nominated base.

- Community and specialist nursing staff in a focus group were aware of the contingency plans for their service, for example in the event of adverse weather, and were aware of their role in those circumstances.
- The trust conducted an annual health and safety audit. The data from 2014/2015 was broken down by business delivery unit. This identified that on average; staff across the trust were 83.3% compliant with core training in health and safety, including modules such as fire safety, first aid, moving and handling, and the use of personal protective equipment. This was below the trust target of 91-100%.

Major incident awareness and training

- The 2014-2015 health and safety audit identified relatively low compliance with emergency planning training. This was on average 69.6% against an average of 83.3% across all modules. This was below the trust target of 91-100%.

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:

- Patients had their needs assessed and care and treatment followed evidence based guidance.
- Pain management and the assessment of patients' nutrition and hydration needs was evidenced in patient records. Referrals to the dietician were straightforward and staff used this appropriately.
- The telemedicine service was integrated with other community services for adults and was proactive in its development of the service.
- Care pathways were coordinated and multidisciplinary working was consistent and effective. Referrals and discharges were supported with information about the transition of patients between services.
- Outcomes for patients were evidenced and audited, which demonstrated the effectiveness of the service.
- Patient's consent to care and treatment was documented in care plans and included the requirements of the Mental Capacity Act where this was appropriate.
- Staff competence was supported by a comprehensive induction for all new staff, values based appraisals for all staff annually, and individualised support for staff development, for example through preceptorships.

However:

- Although clinical supervision was available for staff, it was not recorded formally.
- Although electronic information was available to support staff in their work, the staff intranet did not reflect the full range of services available within community adults and was not particularly intuitive to use.

Detailed findings

Evidence based care and treatment

- Community and specialist health services for adults used guidance from NICE and the Royal College of Nursing. We saw references to and use of national guidelines within a number of services.
- Staff understood their roles and responsibilities in delivering evidence-based care. Staff used nationally recognised assessment tools to screen patients for certain risks and they referred to relevant codes of practice.
- Specialist nursing staff confirmed that NICE guidance was used to underpin their practice, for example in the COPD service and the heart failure specialist service. The tuberculosis nursing service provided services in line with Royal College of Nursing and Public Health England guidance. The weight management service accepted and treated patients in line with NICE guidance for the assessment, diagnosis and management of obesity.
- Other examples included the tissue viability service which used a wound care formulary and followed agreed protocols. The pulmonary and cardiac rehabilitation service provided evidence based exercise and education programmes. The hospital at home service followed NICE guidance for stroke and falls.
- Specialist nursing staff confirmed that NICE guidance was shared at monthly joint operational meetings, which were recorded.
- Patient Group Directions (PGDs) were used in community services based on national guidance for treatments. We reviewed several PGDs used in the service.
- The clinical audit programme for the service included links to national audits. For example, the pulmonary and cardiac rehabilitation service submitted contributions to the national COPD audit programme for September 2015. The hospital at home service completed the national stroke audit.

Are services effective?

- Local audits included record keeping and pressure care which were conducted six-monthly, and an annual health and safety monitoring report.

Pain relief

- Community services supported the review of patients with pain symptoms and used a recognised evidence based pain assessment score.
- Community nursing services used a pain score on the scale one to five and recorded this in the patient's assessment record and pain care plan. Community nursing staff told us they liaised with the patient's GP before administering pain relief.
- Specialist nursing staff gave examples of pain relief applied in community services, for example in the muscular skeletal service where treatment for back pain followed NICE guidance and included the use of acupuncture. Podiatry also used pain scoring. The pulmonary and cardiac rehabilitation service provided an area for cardiac patients to recover from exercise.

Nutrition and hydration

- Community nursing staff told us that patients received a nutritional assessment when this was triggered by their pressure area score. A recognised nutritional assessment tool was used. Nursing staff could refer patients to the dietetics service.
- Specialist nursing staff in a focus group confirmed the assessment for nutrition and hydration formed part of the core assessment in the patient's care plan. Staff told us it was straightforward to refer patients to the dietetics service and to the speech and language therapy service.

Technology and telemedicine

- Community health services for adults included an established care navigation and tele health service to support the delivery of effective care and treatment to patients with long term conditions. The care navigation service provided signposting, referral, advice and support for patients following a crisis. The service provided ongoing coaching and support to promote self-management for patients with long term conditions.
- The Barnsley care navigation tele health service provided telephonic support to patients diagnosed with long term conditions, to encourage improved self-management and positive life style behaviour change.

Patients referred to the service were supported through the delivery of tailored care to suit the patient's requirements, such as help to self-manage and to identify and implement lifestyle changes that could assist their condition.

- Patients were assessed at discharge from hospital for their suitability to use the tele health service. Equipment to support patients using the tele health service was provided by a specialist external supplier which trained and supported patients in the use of equipment in their own home. The care navigation and tele health service undertook daily vital signs monitoring for their patients, for example those with chronic heart failure or COPD, using the remote equipment in the patient's home. The service also undertook telephone coaching for identified patients.
- The stop smoking service offered access via both telephone and instant messaging support. It had also developed an online portal where patients could register and undertake their own stop smoking journey.

Patient outcomes

- We found that the service routinely included questions in patient surveys to identify where patients felt that they had seen an improvement in their condition as a result of the care they received. We saw examples of this across all services.
- The care navigation and tele health service was able to provide evidence, in conjunction with commissioners, of a 40% reduction in non-elective admissions over the previous 12 months, as well as demonstrable reductions (typically 20%) in the emergency admissions of patients who used the service.
- Specialist nursing staff in a focus group told us about a recent review of therapy outcome measures to check their suitability for measuring patient outcomes in the community adults' service. The hospital at home service had commenced using therapy outcome measures for a period of four months at the time of our inspection. This represented a change from the recognised outcome measures (including, in stroke rehabilitation, the standard "Barthel" index) it had used previously, in order to demonstrate more effectively the outcomes of the service for patients. However, audited data was not available at the time of our inspection.

Are services effective?

- Between April and October 2015, the sensory impairment service conducted an audit of patients to identify the improvement in visual and hearing function patients achieved after attending the service. This identified a 40% improvement in 250 patients seen with visual impairment and a 255% improvement in 84 patients with hearing impairment.
- Community matrons told us about a patient activation tool pilot which was taking place and was to be audited and reported. Patient activation supports patients to manage their health. The patient activation measure (PAM) is a patient-reported outcome measure.

Competent staff

- The results from the NHS Staff Survey 2015 showed that 92% of staff had received an appraisal in the previous 12 months. The trust performed in line with the average for staff reporting that their appraisal was well structured.
- The NHS Staff Survey 2015 showed that 73% of staff had received job relevant training, which compared with an average of 77% for similar trusts nationally.
- On average, 84% of non-medical staff had received an annual appraisal as at February 2016.
- Staff confirmed they had received an annual appraisal. Specialist and nursing staff confirmed that new staff received a value based induction.
- Non registered community nursing staff told us they received a meaningful annual appraisal. Qualified nursing staff accompanied non registered staff on visits to observe and sign off their competencies and provide supervision feedback. Staff told us they felt confident to provide effective feedback. Non-qualified staff felt confident to raise concerns if they did not feel they possessed the competencies to undertake delegated tasks.
- As at October 2015, four doctors (87.5% of medical staff) had been revalidated during the last 12 months. As at February 2016, there have been one (100%) doctor revalidated during the last 12 months for this core service.
- The service did not have a central system to collate clinical supervision figures for the non-medical workforce. The service explained that community services staff were required to undertake a minimum of six hours clinical supervision per year.
- Staff told us that clinical supervision was taking place in one to one meetings, in clinical handovers and in team meetings. Staff nurse development meetings were held monthly for band three staff and above. We saw evidence of clinical supervision in team meeting minutes. We found nursing staff we spoke with received one to one clinical supervision monthly to six weekly. However, supervision was not recorded consistently. Senior staff explained that the clinical supervision policy was under review and that one to one recording of clinical supervision was under consideration.
- Student nursing staff spoke very positively about the support they received, with an induction, access to training and personal development opportunities. They worked regularly with their mentor. Qualified nursing staff were proud of the support they provided for students.
- The trust risk register identified risks related to implementing an effective system of revalidation for nurses. This had been identified as having a potential impact on clinical care and service delivery. The trust had identified that additional resources were required to implement nurse revalidation trust wide.
- The trust provided data to show that district nursing staff had been enrolled on specific training programmes for pressure area care in the past 12 months. This included courses in regard to pressure care scoring, heel pressure ulcers, leg ulcer assessment and compression bandage training. The trust provided evidence of course registers to show staff that had attended the courses and the service areas they were drawn from.
- We spoke with staff in the service undergoing preceptorship. This was a twelve month process with regular three monthly performance reviews using a red, amber and green rating. Staff told us that they found preceptorship to be thorough and supportive. We saw that preceptorship records provided detailed documentation of performance reviews and skills development.

Are services effective?

- Specialist nursing staff in a focus group told us they could access clinical supervision, study leave and training. We spoke with nursing staff who were nurse prescribers. Staff we spoke with had completed relevant post graduate non-medical prescribing courses and had supervision available from consultants (for example, in the Tuberculosis (TB) nursing service).

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary working was well developed within community health services for adults. Multidisciplinary meetings were attended by services relevant to the patient pathway, and meetings were recorded. For example, the podiatry service attended multidisciplinary meetings with the physiotherapy service for patients with biomechanical issues. Community nursing staff attended multidisciplinary meetings with staff from the end of life care service when required. Community nursing staff told us they received support from the end of life team at weekends. Specialist nursing staff in a focus group told us the service had well developed links with the local hospice service to support patients with long term conditions.
- Staff in the intermediate care service held daily multidisciplinary meetings, which included therapy and social services representatives, to discuss patients receiving care from the hospital at home scheme or residents in local care homes. All patients were reviewed on at least a weekly basis.
- Community nursing staff returned to their base each day to take part in a formal handover of care. The handover was an opportunity for staff to discuss patient care and the involvement of members of the wider multidisciplinary team. Community nursing staff spoke positively about the level of support they received from other healthcare professionals.
- The care navigation and tele health service attended multidisciplinary meetings to avoid admission which were held in the local area and in neighbouring areas which used the tele health service. Mental health services were represented at these meetings as appropriate.
- The diabetes nurse specialist service received alerts from the local ambulance service when an ambulance attended diabetes patients who had experienced an

emergency episode. This allowed the service to follow up patients in their care. For patients not in their care within the local area, the service followed up alerts with a phone call to check whether the patient needed support.

- The adult epilepsy service had well developed links with the emergency department of the local hospital and held a weekly referral meeting to review emergency admissions. The service maintained similar links with the ambulance service to review patients with an established diagnosis of epilepsy.
- The Parkinson's nurse specialist service attended the regional clinical network as well as a local "Parkinson's excellence" group. This group brought together local clinicians, nurses, allied health professionals, carers and patients.
- Staff spoke positively about the level of integration and partnership working involving the care navigation and tele health service in the multidisciplinary team to support complex patients with long term conditions. For example, the telemedicine monitoring service worked with the local acute hospital, the patient's GP and social services to support the patient.

Referral, transfer, discharge and transition

- A single point of access provided an engagement, triage and assessment for patients accessing community services. A central communications team received referral into the community nursing service. Referrals were recorded and tasked to community services staff through the trust's electronic record system.
- There was open access to care pathways for a number of specialties, including community and specialist nursing. Patients, carers, social care or other health professionals could make referrals. Referrals could also be made through a number of methods, including telephone, fax, letter, e-mail and by tasking services on the trust's electronic record system.
- Staff within community and specialist nursing used the electronic record system to task activities to other specialties to provide an effective transfer of care. This included most local GP's. Specialist staff spoke

Are services effective?

positively about the readiness with which they were able to carry out electronic referrals using a single clinical record. Some specialties (for example, therapy services) used paper based referrals.

- The care navigation / tele health service accepted referrals following an assessment by a specialist nurse, following a patient's self-referral or a referral from their GP. The service reviewed patients discharged from non-surgical wards each day, 24 hours after their discharge. The service reviewed the patient's discharge letter with them and identified clinical requirements were passed to the community nursing team. After three days nursing staff contacted the patient to follow up. For patients identified as high risk, a red (high intensity) pathway was followed for up to 12 weeks. Patients may be stepped down to an amber pathway as their condition indicated, where they typically received one visit per month for six months. A further step down to green was made when the patient's condition was considered to be stable, but required support and coaching to promote their self-management.
- The adult epilepsy service accepted referrals from patients aged over 16 with a diagnosis of epilepsy. Patients were discharged (to an inactive caseload) after a seizure free period. Referral information for 2015 showed that 40% of patients were re-referred from the inactive caseload.
- The hospital at home service worked with the acute hospital to facilitate the patient's discharge and to make arrangements for their care following discharge. Initially the service was provided for a period of six weeks following discharge. Arrangements included support for patients who lived outside the local area.
- Specialist nursing staff told us that following the discharge of a patient from community services, for example from the COPD service, a discharge letter was sent to each individual member of staff involved in the patient's pathway. The letter may also be shared with the patient.

Access to information

- Community services used an electronic patient record system widely used in the NHS. We found that, with three exceptions, GP practices in the Barnsley area used

the same electronic record system. This meant that information could be transferred electronically through the NHS electronic gateway. Live information about patient care and treatment was available.

- Within community health services for adults, each staff group used the trust electronic record system to access care information from other services when patients had indicated that they were happy for this to be shared. This allowed instant access to staff to see the range of care delivered to a patient.
- GP services using the electronic system could be "tasked" in order to forward patient care details and information about patient needs.
- Specialist nursing staff in a focus group spoke positively about the availability of the electronic system and the assistance this provided in making effective referrals.
- The service provided freephone telephone numbers for patient call back.
- Each member of staff received trust communications weekly. Community staff told us they received email communications to their work email address including a weekly newsletter. Staff also received a monthly video communication and said they felt connected to the wider organisation.
- Information was available through the trust intranet to support staff and access was provided to external internet sites. However, staff told us that for community services, information about the range of services provided was not readily available and they did not find the intranet intuitive to use.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Deprivation of Liberty Safeguards provide a legal framework to ensure that patients are only deprived of their liberty when there is no other way to care for them or safely provide treatment and to ensure that patient's human rights are protected.
- The trust had an up to date policy in place to assist staff in complying with the requirements of the Mental Capacity Act 2005 (MCA). The policy also included guidance on the Deprivation of Liberty Safeguards.

Are services effective?

- Staff demonstrated an understanding of consent, MCA and decision making. Patients who used community services were asked to give consent appropriately. Verbal consent was obtained before care was delivered.
- We reviewed consent information for a selection of patients as part of our review of records and found that consent was obtained and recorded. We observed that capacity and consent were specifically marked in district nursing care plans in the electronic system as a prompt for staff to consider capacity issues when delivering care.
- Prior to our inspection the trust confirmed that it did not routinely collect training data in relation to modules on the MCA as it did not form part of the trust's mandatory training programme. At the time of our inspection, staff told us that this had now been introduced as a mandatory training module. We saw that new members of staff were due to attend this training during April 2016.

Are services caring?

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

Summary

We rated caring as good because:

- Care was delivered with compassion and staff treated patients with dignity and respect. The cultural needs of patients were understood and their individual needs were taken into account in the way patients received care. For example, a forum held for patients who used the tele health service which took place during the inspection particularly demonstrated how patient's dignity was upheld.
- Information about the experience of patients who used the service reflected a consistently high level of patient satisfaction, as evidenced by comment cards received from patients who used the diabetes specialist nursing service.
- Patients were consulted and involved in decisions about their care and treatment and were encouraged to contribute to their care plan. Patients understood the goals in their care plan, which was demonstrated for example by patients who attended gym sessions in the pulmonary and cardiac rehabilitation service.
- Patients received emotional support as part of their care. This was demonstrated, for example, by the health integration team and the weight management service.
- Patients' self-care and self-management of their care and treatment was supported. Patients were empowered to manage their own health, and their independence was actively promoted by the service. This was evidenced, for example, by the epilepsy service.

Detailed findings

Compassionate care

- We observed staff interacting with patients in clinics and at appointments in a caring and compassionate manner. Staff engaged with patients to introduce themselves and listened compassionately to patient concerns.
- We observed that staff respected the privacy and dignity of patients. Staff demonstrated a thorough understanding of their care and were reassuring to

patients, their relatives and carers. Staff were sensitive in the way they discussed aspects of the patient's care with them in order to preserve confidentiality. Staff asked patients their preferences as to persons observing clinic interactions and sought consent to share details of medical records with other professionals.

- Patients and relatives spoke highly of the care they received both at home and when visiting the clinic, and said nothing was too much trouble for staff. When we accompanied staff on home visits, patients reported a positive experience, and were very complimentary of the service they received.
- We attended a patient forum for the tele health service. Of the 11 patients present, each one told us that staff maintained their privacy and dignity when delivering care.

Understanding and involvement of patients and those close to them

- The trust carried out a series of patient experience surveys within adult services between October and December 2015. An average of 96.5% of patients reported that they were involved in decisions about their care. An average of 99.85% felt the reasons for treatment and information about medications were explained in an understandable way.
- When we observed care being given to patients, staff gave a full explanation of the care and treatment the patient was receiving. The care plan was patient focused and also involved families and carers. Based on national guidance, carers and patients' families were encouraged to write in the care plan. Each patient we observed felt involved in their care and described being included in decision making about the treatments that the patients received. The patients understood what was to happen in terms of outcomes.
- The health integration team had developed a range of tools to help patients who did not speak English as a first language to understand the care they received. This included pictorial representations of common

Are services caring?

procedures (for example, bronchoscopy) and pictorial information sheets showing the nearest services (for example, opticians were signified with a glasses symbol) with walking directions and maps.

- The care navigation / tele health service provided health coaching sessions using a telephone call to the patient in their home. Each patient who attended the tele health forum felt that they were engaged in discussions and decisions about their care. Two of three carers/ partners present also felt well engaged by staff in their partner's care and the information provided helped to support the self-management of their long term condition. We saw that patient information booklets and short information films for patients or prospective patients were available.
- The diabetes nurse specialist service provided a range of educational sessions for patients. This included an in-house, two week training scheme and evening education sessions to provide patients with information on diabetes and help to empower them to manage their conditions.
- When we observed a gym session provided by the pulmonary and cardiac rehabilitation service, patients were supported with feedback about their progress. Patients discharged from the pulmonary and cardiac rehabilitation service at the end of their programme were given information about exercise groups in their local area which they could consider joining, and signposting to local gym facilities if this was appropriate for the patient's condition. Patients who were attending the rehabilitation gym sessions made positive comments about the impact of the programme and how they had been involved and supported in the longer term management of their condition. Patient information was also displayed in the gym area.
- The adult epilepsy service provided a series of two to three education and guidance sessions to inform patients and their carers in residential care homes.

- We spoke with a patient and their carer visiting a clinic whose appointment had been changed in response to their request for an appointment time that better suited their personal arrangements and they spoke of their appreciation of the flexibility demonstrated by the service.

Emotional support

- The community nursing service offered bereavement visits to families of patients following their death. Staff explained that this could take the form of personal visits or telephone contact depending on the wishes of the family.
- The weight management service linked in with a local eating disorder service so that patients could access psychological support. Staff told us that the service had developed a business case to appoint staff with training in cognitive behavioural therapy in order to widen the emotional and psychological support available.
- The health integration team had registered with a local food bank to obtain food vouchers for clients. Staff told us that they would routinely collect and deliver food parcels to some patients in the most need. This was also evidenced in records and was confirmed to us by a patient we visited. Patients who used health integration were very complementary about the service, describing its involvement as life changing in its emotional impact.
- Specialist nursing staff told us that emotional support for patients with motor neurone disease was available to patients in conjunction with the Motor Neurone Disease Association.
- Qualified and non-qualified specialist and nursing staff in a focus group told us they had received training in giving emotional support to patients with particular conditions, where this was appropriate and supported their role. All patients were allocated a key worker.

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:

- The needs of patients in the community influenced the planning and delivery of services. This was reflected throughout community services but particular examples were the stop smoking service, the health integration team, and tele health.
- The particular requirements of patients with diverse cultural needs were addressed in the planning and delivery of services which was demonstrated by the health integration team as well as other community services. Translation services were available and actions were taken to address inequalities.
- Arrangements were in place to enable access to services for patients in vulnerable circumstances. Patients with a learning disability, patients with dementia, and bariatric patients could access services appropriate for them and their needs were supported. Patients needing care and treatment for their mental health needs could access services in a joined up way.
- The care and treatment of patients with complex needs was managed and coordinated in conjunction with other services, through joined up arrangements and partnerships, for example with the acute sector and with social services.
- Patients had timely access to services for initial assessment and diagnosis, with minimal waits for access to most services. The service reported any waiting times for appointments that exceeded three weeks so that these could be prioritised.
- Patients knew how to complain, although few complaints were received by the service. The service followed the NHS complaints policy and staff knew how to deal with complaints they received. Complaints were investigated and learning was shared with staff.

However:

- Community clinics provided by the district nursing service required review in liaison with practice nursing provided by primary care to ensure community nursing consistently prioritised housebound patients.

- Although the speech and language service saw patients with swallowing problems within two days, the service was not meeting its professional guidance of a two week response for other patients.
- Although podiatry patients were usually seen within six weeks and high risk patients were seen more quickly, patients waited up to four months for some follow up appointments. Recruitment was ongoing but the service had been unable to recruit additional podiatrists.

Planning and delivering services which meet people's needs

- Community services' contribution to the trust's transformation agenda in delivering better services for people with long-term conditions commenced in August 2015. Community services for adults were undertaking a review of the planning and integration of services as part of service transformation. One outcome achieved by this work was the development of the Barnsley community nursing services' operating framework. The operating framework helped in assessing the needs and priorities for the care of patients including those with long term conditions. The coordination and integration of community services, for example including tele health, long term conditions, community matrons and specialist nursing was applied within the operating framework to help ensure the most appropriate services were provided to meet the needs of patients.
- Staff in the health integration team were aware of a projected increase in the migrant population. The service had arranged to meet with the sexual health service to identify how the trust could plan for and meet the health needs of incoming migrant patients.
- The TB service was staffed by one specialist nurse. An enquiry handbook for staff was in use, with guidance documents on health needs and contact details for support, for situations when the nurse was not available.
- The occupational therapy service had commenced a pilot cognitive rehabilitation group for carers. This



Are services responsive to people's needs?

approach followed guidance from the British Society of Rehabilitation Medicine to help carers adapt to changes in their lives when caring for people with cognitive impairment.

- The care navigation / tele health service developed its services proactively to meet the needs of patients. At the time of our inspection it provided a service for 7500 patients. The care navigation / tele health service was awaiting the results of a pilot it had undertaken for patients with long term conditions in the Birmingham area. It also provided a service for patients in Bassetlaw.
- We were informed that the pulmonary and cardiac rehabilitation service was planned and commissioned in response to the local "Breathe Easy" patient group. The service held a "Respiratory pathways meeting" every two weeks which provided outcomes to support the transformation of services.
- Community staff currently provided nursing cover for a number of clinics in community settings which were attended by non-housebound patients. Community nursing staff identified the need to manage the increasing numbers and complexity of their workload by prioritisation of housebound patients and liaison with primary care services as to the role of practice nurses. Community nursing staff identified the need for the service to prioritise housebound patients rather than clinics when demand was particularly busy.
- Specialist community staff told us that providing a review of care plans and risk assessments for patients with long term respiratory problems had been identified as a service shortfall. Planning was in progress to address the needs of these patients through existing joint working arrangements, including those with social services.

Equality and diversity

- The trust had a corporate policy in place for interpretation, translation and transcription. The policy identified how to access both telephone and face to face interpretation, both during and out of hours. The policy also included details of how staff could access text relay services for people with hearing or speech difficulties.
- Community services staff were able to provide examples where the interpreter service was used to support patients whose first language was not English. Staff said

that they could readily access interpreter services via telephone or by face to face interpretation booking. The health integration service had access to a range of foreign language leaflets and patient information.

- The health integration service had developed a range of tools to target the specific needs of the asylum and migrant community. This included a proforma appointment sheet to help patients that did not speak English as a first language engage with GP services. This included tick boxes to identify the type of appointments needed and a brief description of what the patient needed. Patients could then present these to their GP practice to help practice staff identify their healthcare needs. The health integration team provided an individualised service for patients who were hard to reach.
- Specialist staff confirmed that they had received training in equality and diversity. The health integration team provided advice for other community services staff in relation to equality and diversity matters.

Meeting the needs of people in vulnerable circumstances

- The health integration team had identified that migrant workers in the area were not always registered with local GP practices. The team was informed that some of these workers were engaged at a local factory and arranged an event at the factory to raise awareness of community services for migrant workers and to ensure the health integration team was aware of their needs.
- The health integration team provided information to immigrant and asylum seeker groups on hate crime and specific health needs of the groups. The information provided advice and guidance as to how concerns could be addressed by the health integration team.
- Patient with a learning disability who received community services were supported. For example patients with a learning disability were supported to attend gym sessions provided by the pulmonary and cardiac rehabilitation service.
- Bariatric patients who used the community nursing service were supported, for example with equipment and by two members of nursing staff attending home visits.

Are services responsive to people's needs?

- Patients living with dementia who received community services were supported. For example patients were supported to use the hospital at home service. Screening for dementia was undertaken as part of assessment, and strong working relationships and team working across the community services supported this. Nursing staff explained that patients living with dementia were supported by using a range of possible approaches to undertake care procedures.
- Mental health services were accessible as they formed part of the same trust as community health services for adults.
- Specialist nursing staff discussed with us the response times for referrals to their services. Overall, most community services responded to patients after only a short wait following referral. The electronic record system had improved the responsiveness of services.
- Data provided by the trust showed that the musculoskeletal service was exceeding timescales for referral to treatment under its pathways, with 98.9% (against a target of 92%) and 99.5% (against a target of 95%) of patients receiving treatment within the target time between April and September 2015.
- The health integration team operated a drop in service for patients during office hours. The drop in service allowed patients to access support at times that suited them.
- The tuberculosis nursing service had commenced operation from a satellite clinic in the local area (Wombwell). The satellite clinic allowed patients from the migrant and asylum community to access care more quickly, without the need and cost of travelling to central Barnsley.
- The intermediate care service offered a rapid response service which covered out of hours care from specialist and community nursing. The service aimed to respond to calls within four hours. At the time of our inspection, the four hour target had recently been agreed with commissioners, and information to demonstrate the four hour target was being achieved was not available.
- The pulmonary and cardiac rehabilitation service recorded an average waiting time in days from referral to a face to face meeting with the patient in the range of 7.5 to 17.3 days for the previous 12 months. However, this did not take into account that contact made with the patient before the initial face to face meeting in which patients were prioritised according to risk.
- The adult epilepsy service confirmed that there was no waiting list for patients to be seen.
- The heart failure specialist nurse service saw patients referred for prevention within two weeks.
- The tissue viability service visited patients within a waiting time of 21 days, meeting the local target of three weeks. For nurse led clinics for leg ulcers, response times were nine to 11 days at the time of our inspection.

Access to the right care at the right time

- The service was delivering its Commissioning for Quality and Innovation (CQUIN) target for the percentage of patients with confirmed transient ischaemic attack (TIA) or minor stroke who have a structured follow up assessment within one month.
- Referral to treatment data for the 12 months to January 2016 showed that patients were assessed promptly for care and treatment. The percentage of patients seen within 18 weeks consistently exceeded the 95% target for non-admitted patients, and in four of the previous 12 months was recorded as 100%.
- The service reported any waiting times for appointments that were above three weeks. The latest data provided by the trust for September 2015 showed that only four services (occupational therapy (five weeks), podiatric nail surgery (three weeks), musculoskeletal services (seven weeks) and physiotherapy (three weeks) reported waiting in excess of this target.
- Between January and December 2015, the average length of wait from referral to the first contracted activity with district nursing services was 5.5 days. At our inspection we found that this represented an average, when the typical response was much quicker. In practice the district nursing service did not operate a waiting list. Response information was confirmed by a review of the electronic record system. Patients were made aware of how to contact the district nursing service between visits.

Are services responsive to people's needs?

- Physiotherapy and occupational therapy patients were usually seen within three weeks of referral.
- For the speech and language service, responsiveness in the community was variable. For patients with swallowing problems the response time was two days. However, in responding to other patients, the service was not meeting its professional guidance of a two week response.
- Podiatry patients were usually seen within six weeks and high risk patients were seen more quickly. However, podiatry also explained that for some follow up appointments, the patient waited up to four months.
- Community matrons told us that patients referred to the service received a telephone response within 24 hours. Visits took place within five days of referral. Community matrons planned to undertake an audit of response times to verify the service response times.
- In 2014-15 a total of 23 complaints were received relating to adult community services and all complaints were upheld. No particular trends or themes were identified in these complaints. No complaints were referred to the Parliamentary and Health Service Ombudsman. The physiotherapy /musculoskeletal service had the highest number of complaints with seven and all of these were upheld.
- In the community locations we visited we observed there were notices displayed which advised patients and relatives about how to make a complaint and provide feedback about the service. We also saw displayed action taken in response to complaints.
- Allied health professionals confirmed that their services each had leaflets available for patients which informed them how to make a complaint. Staff gave as an example of change made as a result of patient feedback that patients were previously uncertain how to complain and in response to patient comments the patient information pack about how to make a complaint was improved.

Learning from complaints and concerns

- The trust received 265 complaints in 2014-15 compared to 338 received in 2013-14.

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:

- Services had a clear vision focussed on the patient at the centre and staff understood how the strategy for their service linked to the overall aims of community services and the wider organisation.
- Risks to the delivery of care for patients were understood, managed and action taken appropriately to mitigate them.
- Governance arrangements consistently supported the delivery of the strategy and care for patients. Team and service meetings for staff were held regularly and recorded. Performance measures were used which were understood, reported and monitored and action was taken when issues were identified.
- The service demonstrated a positive, focussed culture in which teams worked well together, which encouraged openness and consideration for staff well-being.
- Community services engaged with patients and the public and consistently positive feedback was evidenced, for example 98% of feedback from the Friends and Family test.
- Service leaders were visible and seen as approachable by staff.
- The trust's transformation agenda was in progress and in some community services the project was embedded, for example community nursing.
- Community services operated in an environment that encouraged improvement and innovation, which was evidenced in most services, but particularly in tele health and care navigation, and health integration.

However:

- Lines of accountability to the senior management team were not always clear to staff in front line services and awareness of the governance arrangements for community services by the trust's senior management team required development.

There was more to do to engage staff in the transformation of specialist services.

Detailed findings

Service vision and strategy

- The trust mission was to enable people to reach their potential and live well in their community which was supported by six key values. The mission and values were produced in liaison with patients, carers, staff and partners.
- We saw that "Our mission, our values" was displayed in community service bases we visited. We found staff we spoke with were able to describe the aims and objectives of the service. Staff consistently presented a "patient first" or "patient centred" vision for the service which was aligned with the trust mission and values. Patients and families were right at the centre of care.
- Specialist nursing staff in a focus group said that staff acted as role models for trust values and worked to them.
- The service had implemented value based appraisals for staff to align with the trust's vision and values.

Governance, risk management and quality measurement

- A risk register was maintained for community services which reflected current risks. For example, the Barnsley business delivery unit identified risks linked to the introduction of flexible ("agile") working. Identified risks included concerns as to the full utilisation of the electronic record system linked to the need to maintain some paper records, and the availability of records at the point of care. Additional concerns had also been identified about the facilities for storage of records, as well as the process for retrieval and destruction of records. At the time of our inspection, the majority of staff we spoke with were using the electronic record system. An agile working pilot was in place and staff in the pilot told us that they found agile working to be helpful in their work.

Are services well-led?

- Community and specialist nursing staff confirmed that assessments of risk were undertaken linked to the risk register and that these were in place.
- Regular governance meetings took place within the services we visited. Meetings held included monthly “trio” meetings of senior managers, monthly or bi-monthly management meetings within services, and operational meetings held regularly in specialist services. A monthly meeting was attended by both community nursing and specialist nursing. Community and specialist nursing staff confirmed that operational meetings were held monthly and that these were minuted.
- Regular team meetings took place, which were held weekly for some services, for example district nursing localities, and monthly for others, for example the hospital at home service. Staff nurse development meetings were held monthly for qualified and non-qualified staff.
- We found that meeting minutes were comprehensive and that agendas were arranged in accordance with the CQC inspection domains and included actions to be taken. We saw that meetings included feedback for staff from attendees at senior meetings, risk identification and discussion, updates on quality targets, and learning being shared.
- Community services employed “practice governance coaches” as part of the senior leadership team. These members of staff had no operational management role and instead focused on governance and quality improvement measures. Their role included involvement in risk management, incident reporting, complaint investigation and the transformation agenda.
- Community and specialist nursing staff in a focus group were able to describe how the governance arrangements in their service and locality were linked to the overall governance of the service. However, not all staff were familiar with the “trio” arrangement of senior managers.
- Senior staff in specialist services attended clinical update meetings for their specialism. For example, the heart failure specialist nurse attended update meetings in the acute cardiology service.

Leadership of this service

- The results from the NHS Staff Survey 2015 showed that the trust performed within the best 20% of trusts, with low rates of staff reporting discrimination at work.
- Within community health services for adults, all staff we spoke with felt well supported by their immediate line managers. Staff told us that open door policies were operated by their managers and they felt they were supported by their managers, with guidance available when they needed it. Staff spoke positively about the leadership of their locality and the clinical leadership of their service.
- The trust was in the process of establishing a leadership development framework. In July 2015 the trust requested an external organisation to audit progress. The external audit provided a rating of “significant assurance with minor improvements opportunities”, with three of nine recommendations from a 2014 leadership development report being fully implemented.
- The health integration team had conducted a “well led” audit to identify areas where leadership needed to be strengthened. This had resulted in actions, such as protected team meeting times once per month.
- Community and specialist staff described their experience of leadership as providing a clear pathway and understanding of line management and professional leadership. Staff felt the local management structure was visible, but that wider management was not so visible, with the exception of the chief executive. Staff felt that community services was not visible within the wider trust. Staff cited the lack of information about the range of community services on the staff intranet as an example.

Culture within this service

- Nursing staff spoke very positively about the culture they worked in and the support they received. There was no blame culture. Student nursing staff told us they enjoyed their role and felt welcome. Qualified nursing staff said they were most proud of what the team achieved through teamwork and were proud of the support they provided for students. Specialist nursing

Are services well-led?

staff in a focus group told us that the culture reflected the fact that staff enjoyed work and were proud to work in Barnsley. Peer support was described to us as excellent and the culture of caring was felt by staff.

- The care navigation / tele health service was described to us as a strong team culture, with staff finding each other very approachable. Both the weight management service and the stop smoking service had recently lost staff due to services being recommissioned. Staff we spoke with within the services told us that they had felt well supported by the trust and senior managers during this process.
- Staff in the health integration team did not feel that their role was fully understood by senior managers or other staff within the trust.

Public engagement

- We saw the results of the most recent monthly NHS Friends and Family test for community health. For 703 responders, 82% of these were extremely likely to recommend the service.
- The service undertook patient and public involvement audits two or three times annually within services to gauge patient satisfaction. These audits asked a range of questions, including whether appointment times were suitable and whether patients felt involved in their care, and asked patients to rate the services provided.
- We saw the results of the most recent patient participation survey in a community base we visited. The service user information displayed showed all satisfaction scores were above 80%. Staff informed us that an action plan was prepared for any responses which scored under 80%.
- The service carried out a series of patient experience surveys within adult services between October and December 2015. Each survey asked five questions about patients being involved in their care, having time to discuss concerns, understanding the care they received, having privacy and dignity maintained, and if patients knew how to contact the service. Many areas scored 100% satisfaction, with no average rating being below 96.6%.

- Community services received 260 compliments from members of the public in the 12 months prior to our inspection of which 135 were received by one health trainer's team in Wakefield.
- The equipment, adaptation and sensory impairment service conducted a patient experience survey in October 2015. This identified that 100% of patients (54) would recommend the service to others.
- The health integration team held health promotion events in the community. The events were held at local schools and local business to raise awareness of the role of the health integration team and of how services could be accessed.
- The Parkinson's nurse specialist service engaged with the public by working closely with local charities, including the provision of an exercise group for patients and carer support days.
- In the pulmonary and cardiac rehabilitation service, we saw there was a suggestion box located in the gym.
- For the service that care navigation and tele health provided in the Bassetlaw area, the service attended patient focus groups arranged with primary care as part of their contractual arrangements.
- Allied health professional staff and community matrons told us in response to patient feedback at consultation events, physiotherapy staff were more responsive in taking equipment to patient's homes. The location of clinics had also been changed in response to patient feedback. Further examples in response to patient feedback were reducing the number of assessments to one assessment, and making changes to patient information and developing patient leaflets, for instance about the heart failure specialist service. We found the heart failure specialist service had reached the tenth anniversary of its patient support group which was attended by up to 40 people.

Staff engagement

- Staff within community and specialist nursing were part of a transformation working group. The working group fed into a strategic level group so that front line staff could provide feedback and discuss ideas about the transformation of services. Staff told us that they

Are services well-led?

received regular updates on the transformation project from their managers and had been given the opportunity to comment on proposals through their managers.

- Community specialist nursing staff in a focus group said community service staff had felt involved in the development of the nursing strategy and in integration within the mental health trust.
- In a focus group for allied health professionals and non-qualified nursing staff, some staff told us they did not feel connected into the strategic transformation work and some staff were not aware of the transformation agenda. However, staff said they felt they would be listened to if they had ideas to improve the service.

Innovation, improvement and sustainability

- Excellence awards were used within the service to recognise and celebrate success, linked to care for patients. The award scheme was available to all the teams in the service.
- The service had developed a drop-in mobility clinic for patients with mobility and falls issues. The clinic had been extended to cope with increased demand. Patients attending were screened for falls and follow up assessments were arranged if required.
- The service was developing a core nursing assessment for community services. The core assessment provided a single, comprehensive initial assessment tool for patients entering the service. We saw that this would include basic personal and health information, as well as basic core assessments of need (for example, a Mental Capacity Act 2005 assessment).

- Resuscitation services undertook external training in resuscitation which provided additional resources for investment in community services.
- The care navigation / tele health service linked with other community services in promoting patient self-management of long term conditions. The care navigation service provided signposting, referral, advice and support for patients following a crisis. The service provided ongoing coaching and support to promote self-management for patients with long term conditions. Health coaching was linked, for example, to weight management. The service could demonstrate its effectiveness in preventing hospital admissions. The care navigation / tele health service supported the care and treatment of 7500 patients.
- The operating framework helped in assessing the needs and priorities for the care of patients including those with long term conditions. The coordination and integration of community services, for example including tele health, long term conditions, community matrons and specialist nursing was applied within the operating framework to help ensure the most appropriate services were provided to meet the needs of patients.
- The stop smoking service offered access via both telephone and instant messaging support. It had also developed an online portal where patients could register and undertake their own stop smoking journey.