York Teaching Hospital NHS Foundation Trust

RCB

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RCBAW	Archways Intermediate Care Unit		YO31 8HT
RCBL8	Malton Community Hospital		YO17 7NG
RCBTV	St Helen's Rehabilitation Hospital		YO24 1HD
RCBP9	White Cross Court Rehabilitation Hospital		YO31 8FT

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall, we judged that community health services for adults were good, although some aspects of safety required improvement.

Incidents were reported across teams and serious incidents were investigated using root cause analysis, although staff received little feedback to share learning from incidents. There was a policy in place relating to the Duty of Candour requirement. The safeguarding adults policy was applied as part of practice, although safeguarding adults training was not up to date for a significant number of community services staff. The service had robust systems in place for the management and use of controlled drugs. Correct infection control techniques were followed. Staff demonstrated a sound awareness of key risks to patients and were proactive in responding to identified risks, although some local risk management arrangements lacked robustness.

The service faced some challenges with workforce planning and recruitment. Mandatory training participation rates for all modules across community services (except fire safety) fell below the trust minimum compliance target of 75%. Staff working alone were supported using informal procedures that were applied quite loosely in some teams; this meant that staff had some concerns regarding their own safety, particularly in the evening and at weekends. Some locations provided cramped facilities for staff and, outside the city of York, delays were encountered in the supply and maintenance of equipment, which potentially affected patient safety.

Policies and best practice guidelines were used to support care and treatment and staff understood their roles and responsibilities in the delivery of evidence-based care. A recognised assessment tool supported by national guidance was used to support the review of patients with pain symptoms. Nutrition and hydration assessments were usually completed, and patients were referred appropriately to specialist services. The NHS Safety Thermometer was completed. The service had an audit programme for 2014/15, but audits in community services were limited and there was no clinical audit plan in place.

Staff received annual appraisals and staff development and training were supported through a learning hub. Mentoring arrangements were used and a competency framework for therapy staff was being implemented from April 2015. Not all services were aware of clinical supervision arrangements. Multidisciplinary team meetings were held for complex patients and good relationships existed with primary care. Poor communication about the patient pathway was being addressed by working collaboratively. Most staff had an understanding of the Mental Capacity Act.

Patients and relatives were treated with respect, dignity, and compassion. Staff respected patient confidentiality in discussions with patients and their relatives and in written records or other communications. Staff provided emotional support to patients and their relatives.

Patients were assessed promptly for care and treatment and referrals were triaged. Any patient who was deemed to be an urgent priority was seen very promptly, usually within five working days. The single point of access did not currently include therapy services and there was no overnight or weekend community nursing service in Scarborough or Ryedale. Communication with hard-to-reach groups in the Scarborough area included good examples of involving homeless people and those who used substances. The service received few complaints but learning from the investigation of any complaints was shared.

The dementia strategy needed development for community-based services. We found evidence of poor access to services for some patients with a learning disability and some communication issues with mental health services. The timely supply of equipment for bariatric patients needed to be addressed. Discharge liaison arrangements between the acute hospital and community settings required some refinement.

The management arrangements for community services were being reviewed. An assistant director of nursing had recently commenced in post with specific responsibility for community services. The governance structure of the trust included an operational community services group. A central risk register was in place for community services but we identified some concerns regarding the escalation

Summary of findings

of risk. Senior staff met monthly to review clinical and managerial issues, to develop action plans resulting from audits, and to share learning. Learning was also shared at regular team meetings with nursing staff.

Recent changes to the structure of community services were viewed positively by staff. Staff mainly identified with the trust's mission statement and followed its values, although no specific vision or strategy had been developed for community services. Senior community nursing staff were supported by senior nurse management. Clinical leadership required development. We found a mainly positive culture in community services although several teams told us that there was a hospital-focused, acute culture in the organisation with York seen as the centre. The service was a national pilot site for the development of community hubs to support the delivery of care nearer to home.

Summary of findings

Background to the service

Community services for adults with long-term conditions were part of the York Teaching Hospital NHS Foundation Trust. The trust took over the management of some community-based services in Selby, York, Scarborough, Whitby and Ryedale in April 2011. This included some community nursing and specialist services as well as Archways in York, St Monica's in Easingwold, the New Selby War Memorial Hospital, Whitby Hospital and Malton Hospital. The community services directorate included community health services with about 112,000 community patient contacts and more than 300 whole-time equivalent registered nursing staff. Services operated from a range of facilities including five community hospitals, as well as primary health centres and general practices.

Allied health professionals' (AHPs') community therapies services for adults were part of the AHP and psychological medicine directorate. During 2014, occupational therapy and physiotherapy services were combined within the AHPs' adult community therapies team.

York Teaching Hospital NHS Foundation Trust provides a range of acute hospital and specialist healthcare services for approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale, an area covering 3,400 square miles. The trust provides community-based services in Selby, York, Scarborough, Whitby and Ryedale. The trust operates from 12 locations, of which 10 are hospitals associated with this teaching trust, three of which are classified as acute district general hospitals, three are community hospitals and two are rehabilitation hospitals. There are also a number of satellite renal units.

The Indices of Multiple Deprivation indicate that York is the third least deprived city (out of the 64 largest cities in the UK) and is the eighty-seventh least deprived borough out of the 326 boroughs in the UK. North Yorkshire is a relatively prosperous county compared with the rest of England, although there are pockets of deprivation. Eighteen lower layer super output areas (LSOAs) within North Yorkshire are among the 20% most deprived in England. Fourteen of these LSOAs are in Scarborough district (around Scarborough and Whitby), two in Craven district (around Skipton), one in Selby district and one in Harrogate district.

Our inspection team

Our inspection team was led by:

Chair: Stephen Powis

Team Leader: Adam Brown, Head of Hospital Inspection, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: doctors, nurses, therapists, a school nurse, a health visitor, district nurses, community matrons, a GP and experts by experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service-specific information provided by the trust as well as information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 17 to 20 March 2015.

During this inspection we met with more than 100 managers and staff representing a range of roles and seniority. We included qualified nursing staff, specialist nurses, AHPs (physiotherapists, occupational therapists and speech and language therapists), healthcare support workers, team leaders and managers. Interviews were conducted on a one-to-one basis, in small groups of two or three staff within a service, or in group discussions arranged as focus groups.

Inspectors spoke with more than 20 patients in a number of settings. We visited clinics, and we accompanied community nurses to observe patients receiving care at home as well as to talk with patients and their relatives about their experience of the service. We contacted some patients by telephone to ask their views about the care and treatment they received. We also received feedback from patients who had completed comment cards.

We held a listening event on 12 March 2015 in Scarborough and on 16 March 2015 in York to hear people's views about care and treatment received at the hospitals. We also held a number of community focus groups before the inspection visit; these were attended by patients from established community networks. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events and focus groups.

What people who use the provider say

The Friends and Family Test had been used in community services only since February 2015. At the time of our inspection, no feedback had been received by the service. The service used "Knowing how we are doing" boards that provided a focus for patient experience, including use of the Friends and Family Test feedback.

Patients we spoke with were positive about the care and treatment they received. Patients and their families said that they felt supported and helped by the nursing staff who visited them. This was especially true where the patient was visited by the same member of staff; in these cases, the patient felt that continuity of care had improved and this supported their understanding.

Letters and comment cards received from patients were displayed in community locations. Comments made about the community nursing service were consistently positive and expressed gratitude for the level of service provided. Community nursing staff in a focus group shared examples of feedback they had received from patients that illustrated patient satisfaction with the service. In three primary care locations we visited where community service staff were based, we found that "Your experience matters" audits were conducted to capture the views of patients, although we did not review the results of these. In each location we saw evidence that patients had commented positively on the service; a selection of these comments were displayed.

We reviewed the results of several service-specific patient satisfaction surveys, for example for the continence advisory service. The audit survey conducted in 2015 for the York and Selby area showed a high level of satisfaction with the service and the advice provided had improved quality of life for most patients. Each of the respondents stated that they would recommend the continence advisory service to friends and family.

Summary of findings

Good practice

The service was a national pilot site for the development of community hubs to support the delivery of care nearer to home. Two community hubs, based at Malton and Selby, had been established to support seven-day assessment for residents of care homes; this enabled early intervention and reduced the need for crisis intervention.

We found examples of communication with hard-to-reach groups in the Scarborough area that had been developed by community therapy services in response to the needs of the local community, including homeless patients and patients who used substances. Staff were sensitive to the challenges that this presented to community services, and were empathetic in their approach to patients.

In therapy services, commissioners had supported a project to develop a triage process, prioritisation criteria and a referral system linked to outcome measures for assessing the effectiveness of the service for patients.

In Easingwold, nursing staff had developed an indexed guide and directory of services in the area for the public, patients and staff to use.

A primary care setting in Acomb used a range of audits effectively to support improvements in practice. For example, a record-keeping audit was undertaken each month using a set of notes selected randomly that was examined with the nursing team. The audit had been taking place for six months and was an example of good practice.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must review arrangements to support staff working alone to ensure their safety.
- The trust must ensure that staff are supported to undertake their statutory and mandatory training.
- The trust should review arrangements for the supply and maintenance of equipment to ensure that it is provided promptly to patients to support their needs.
- The trust should review arrangements to support adequate staffing of all community nursing teams within the trust to ensure that patients are not placed at risk, particularly overnight and at the weekend.
- The trust should ensure that patients' notes are completed accurately and in a timely manner. The trust should also ensure that staff can gain appropriate access to shared care records.
- The trust should review arrangements for the escalation of risk in community services. The trust should also ensure that staff receive feedback from the investigation of incidents and are supported to share learning.
- The trust should ensure that all relevant staff are kept up to date with plans to respond to major incidents.
- The trust should ensure that suitable and appropriate premises for the use of staff and patients.

York Teaching Hospital NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Within the York area, we found that arrangements were in place to ensure the safety of equipment. Outside the city of York, equipment was obtained from an alternative equipment supplier and delays were encountered in the supply and maintenance of equipment; this potentially affected the safety of patients in their homes. Some locations, for example Selby and Scarborough, had cramped facilities for staff and were unsuitable for visits by patients.

Referrals were completed electronically and actions taken were documented. Staff expressed concerns about and difficulty in gaining access to shared care records and inconsistency in completing patient notes; this presented some risks to the safe care of patients, as well as to the safety of staff. Staff working alone were supported using informal procedures that were applied quite loosely in some teams; this meant that staff had some concerns regarding their own safety, particularly in the evening and at weekends.

We found the service faced challenges with workforce planning and recruitment. Action was being taken to reduce variations in staffing levels in some teams, particularly at the weekend, to ensure that patients were not at risk. Mandatory training participation rates for all modules across community services (except fire safety) fell below the trust minimum compliance target of 75%.

Incidents were reported consistently across teams and staff used the reporting system appropriately to record and report incidents. Serious incidents were investigated using root cause analysis and action plans prepared, although staff received little feedback to share learning from incidents. There was a policy in place relating to the Duty of Candour requirement.

The service had a safeguarding adults policy and procedure in place that staff applied as part of their practice. However, safeguarding adults training was not up to date for a significant number of community services staff.

Requires improvement

Are services safe?

The service had robust systems in place for the management and use of controlled drugs and regular compliance monitoring was undertaken by the trust's pharmacy service. Incidents relating to the management of controlled drugs were investigated.

Correct infection control techniques were followed.

Staff demonstrated a sound awareness of key risks to patients and were proactive in responding to identified risks, although some local risk management arrangements lacked robustness. Foreseeable risks and changes in demand due to seasonal fluctuations were planned for and staff were generally aware of emergency arrangements. Contingency plans were in place to respond to major incidents, although not all community matrons or community nursing staff were familiar with these arrangements.

Detailed findings

Incident reporting, learning and improvement

- Between January 2013 and December 2014 the trust reported a total of 46 serious incidents in community hospitals or other settings in the community, including in patients' homes. The majority of these (33) were grade three and four pressure ulcers: 27 were grade three and six grade four. The remaining 13 incidents were slips, trips and falls. Of the total number of incidents occurring in community settings, 21 took place in patients' homes.
- The service reported incidents using an electronic incident-reporting system widely used in the NHS. We found that incidents were reported consistently across teams and staff used the reporting system appropriately to record and report incidents.
- Serious incidents were investigated and action plans prepared. Incident information was analysed by service and base and by category and type of harm, with themes and trends identified. We reviewed data covering incidents that had occurred in the six months prior to our inspection. A review of incidents occurring across the trust, including in community services, took place weekly and a serious incident report was prepared. For example, for any incident involving a stage three pressure ulcer, a root cause analysis and an investigation were undertaken. Community staff we spoke with at three locations described how they had progressed the action plan and recommendations following the root cause analysis of recent incidents; action had included communication with external care agencies and training on pressure ulcer prevention.
- Senior nursing staff in a focus group told us that community nurses were represented at the professional nurse leaders' forum that focused on the investigation of incidents involving pressure ulcers, falls and medication errors. The forum undertook root cause analysis, action planning and the identification of lessons learned. Each death of a patient in the community was the subject of a mortality review.
- Community staff we spoke with described the process they followed to report incidents and were able to provide examples of incidents they had reported. Staff had established lines of communication for reporting incidents within the district nursing team, general practice and the multidisciplinary team. When a full root cause analysis was completed, the staff directly involved were invited to attend the incident review panel. The locality manager provided feedback to staff following the conclusion of the panel enquiry.
- Risk and legal teams were notified of the outcome of investigations. In the case of pressure ulcer incidents, the tissue viability team was also notified. Action plans from the investigation of incidents were discussed at nursing staff meetings, which were minuted. Training to support incident reporting had recently been completed by some staff we spoke with.
- Staff in a focus group and in some teams and locations we visited told us that they received little or no feedback about incidents they had reported. One member of staff who attended an investigation panel told us that nothing had changed as a result of the investigation they were involved in. Some members of staff told us that they had received no feedback, although they had requested this to inform learning. Other staff confirmed that there was limited sharing of learning between community teams.
- In one location we visited, staff were unclear about who was responsible for reporting and following up incidents, and we found two incidents waiting to be actioned. In another location, we found that there was a backlog of 10 incidents which were still to be input into the system. The member of staff responsible was expecting to review these within the next week.

Requires improvement

Are services safe?

- We were informed that locality managers shared relevant safety alerts with staff, although we did not see evidence of this. We saw that learning from incident reports and information about root cause analysis training were displayed on staff noticeboards.

Duty of Candour

- In November 2014, the Duty of Candour statutory requirement was introduced and applied to all NHS trusts. The trust had a policy in place relating to this new requirement.
- Information to be reported under the Duty of Candour requirement was included in the electronic incident-reporting system. Staff told us that Duty of Candour training was included in staff training on handling incidents.
- We saw that information about the Duty of Candour was displayed on staff noticeboards in the locations we visited, and was available on the staff intranet. Staff we spoke with were aware of their responsibilities under the Duty of Candour requirement.

Safeguarding

- The service had a safeguarding adults policy and procedure in place. Staff we spoke with were able to explain how they applied the policy and demonstrated that they understood and used it as part of their practice by discussing examples they had encountered. A community nursing team (in Scarborough) had been nominated for the trust's 'Star' award for the escalation of concerns about inappropriate care in a residential care setting.
- Our review of the minutes of the safeguarding adults group meeting held in December 2014 showed that there were no alerts raised about care delivered by community services.
- Staff received training in safeguarding as part of their mandatory training. Training attendance information we reviewed showed that 54% of staff in community teams had received level one training in the previous three years, against the trust's target of 75%. Staff in the teams we spoke with had received safeguarding level two training for both adults and children. Some teams reported that they had encountered no issues in arranging safeguarding training. Information we reviewed confirmed that 139 professional, medical and registered nursing staff working in community services had received safeguarding level three training. We reviewed local training registers and found that safeguarding adults training was mainly up to date. However, senior staff confirmed that some community teams had encountered a problem arranging further safeguarding adults training, as there was a shortage of places.
- In several locations we visited we saw that information for the public and staff about safeguarding matters was displayed on noticeboards.
- Senior nursing staff in a focus group told us that safeguarding risks were included on the agenda of multidisciplinary meetings, which were held weekly. Information was shared within and between community teams, for example with health visitors. General practitioners and local authority social services safeguarding staff provided advice and support. General practitioners also reported a positive relationship with the trust in relation to safeguarding matters.

Medicines management

- Medicines were generally found to be prescribed, supplied, stored and administered appropriately.
- Controlled drugs were handled appropriately, with the involvement of the general practice where necessary. This was corroborated by an internal audit report for the period January to June 2014 that related to controlled drugs and included community settings.
- The service had a policy and standard operating procedures covering the management of controlled drugs. This was available to staff on the trust intranet. The service had robust systems in place for the management and use of controlled drugs and regular compliance monitoring was undertaken by the trust's pharmacy service. Incidents relating to the management of controlled drugs were investigated.
- There were systems in place to ensure that controlled drugs were stored and transported appropriately between locations in the community.
- Training in the administration of medicines was undertaken by appropriate staff groups. Community nursing staff we spoke with had attended annual training in the administration of medicines; we confirmed this when we reviewed training records. Community non-medical prescribers received annual update training with revalidation. Appropriate nurse prescriber coverage of community areas supported the

provision of safe care in the administration of medicines. However, staff in a focus group confirmed that the availability of training in medicines management remained an issue for them.

- We checked the arrangements for medicines management at each of the locations we visited, and observed practice during visits to patients' homes. We reviewed a selection of drug administration sheets. Patient group directions were checked for patient administration of medication. Staff were aware when medication errors had occurred; these were reported as incidents and were followed up. However, staff in a focus group were unsure about how lessons were learned and disseminated following the investigation of incidents involving the administration of medicines, and were unable to confirm whether they had received any feedback from investigations.
- Non-medical prescribers completed annual audits of medicines management.
- Staff in a focus group confirmed that medicines management was included on the service's risk register. Staff were aware of a range of initiatives to improve safety, such as revised prescribing documentation.

Safety of equipment and facilities

- Within the York area, we found that arrangements were in place to ensure the safety of equipment. Equipment was supplied promptly and maintained correctly.
- Training and arrangements were in place to assess the competency of staff in the installation and use of equipment. Equipment training updates were used so that staff could demonstrate the safe use of equipment.
- The equipment store maintained a record of when each item of equipment was due for servicing. Engineers from external suppliers made arrangements directly with patients to visit their home to service equipment. Similar arrangements applied for equipment breakdowns. Other items of equipment, for example blood pressure machines, were returned to the supplier for cleaning and maintenance. Arrangements were in place for the return of used equipment.
- Information we received as to numbers of delayed discharges from hospitals awaiting community equipment and adaptations for April 2013-14 showed that the actual number waiting was 607, which was 3% of the total compared to 2.8% nationally.
- In rural areas of North Yorkshire, outside the city of York, equipment was obtained from an alternative equipment supplier. Community nursing and therapy staff at several locations we visited told us that they encountered delays in the supply and maintenance of equipment, including beds. Pressure-relieving aids were in particularly short supply. Staff informed us that they received no overall guidance on the use of pressure-relieving equipment. The procedure for ordering equipment, including beds and mattresses, required a staff signature; staff told us that this introduced further delays. Arrangements for the maintenance of equipment were also unclear to staff. We found that there was no indication on the equipment of the date it was next due for servicing.
- A revised online ordering system for the requisition of equipment had recently been introduced. We were informed that equipment typically took a week to arrive, although equipment requested was not always available. Patients or relatives could make arrangements to collect equipment. We found that staff often transported equipment such as commodes themselves to minimise waiting times. Staff informed us that there were significant waiting times for some key items of equipment, including mattresses, commodes and beds, but the ordering system did not provide information on the likely waiting time. Arrangements were in place for items to be hired from an external supplier of medical loan equipment. However, staff also expressed concerns as to the delays and difficulties they encountered in accessing equipment for patients through the equipment loan service, which potentially delayed the discharge of patients from hospital.
- When we accompanied nursing staff visiting patients in their homes, we checked the service dates of equipment and found that it was in date. However, in some instances we found that patients had been waiting for equipment parts for several weeks. This potentially affected patient safety at home.
- Some locations we visited, for example Selby and Scarborough, had cramped facilities for staff and were unsuitable for visits by patients. During our visit, some staff expressed concerns to us about the shortage of suitable office and desk space. The very restricted office and clinical space limited the functionality of staff. Flexibility to see patients was limited by a lack of clinical rooms. We were informed that staff had escalated these concerns.

Requires improvement

Are services safe?

Records and management

- The service had recently introduced an electronic patient record in its community settings. The redesign of documentation used by staff coincided with this. A documentation working group had prepared an action plan to support improvements to the documentation used by staff. The community nursing team was represented on the documentation group, which aimed to improve the consistency of documentation and reduce the duplication of records across the trust, including in community services. We were informed that some nursing teams, for example in Selby and Filey, were shortly to undertake a pilot using handheld devices.
- During our observation of patient care, we reviewed a sample of patient records on the computer system. Initial assessments, risk assessments, care plan reviews and consent information were completed. Referrals were completed electronically and actions taken were documented.
- Paper versions of patient records were maintained in the set of notes in the patient's home. When we accompanied staff on home visits, we observed that notes and care plans were completed appropriately in the patient-held record.
- However, we received information in which staff expressed concerns about patients' handheld notes not being fully completed. Staff said that assessments and evaluations were rushed and at times they were completed poorly. Staff also visited an office location each day to input notes into the electronic patient record, which involved some duplication. At one location we found that community nursing staff regularly photocopied documents (for example, immunisation records) and physically transferred these to the adjacent GP practice so that the practice records could be updated. We found that some staff used notes made in their diary to update the electronic patient record from memory, which presented some risk that information captured in the patient-held record could be missed.
- AHPs used standardised documentation across the trust, and this provided an appropriate focus for therapy teams. The use of standard documents supported collaboration with other teams across the trust, including community nursing.
- The computerised records management system used in most GP practices where community-based staff worked was the same as the main system used in the trust; this enabled information sharing with some practices. However, in some areas, such as Selby, general practices used a different IT system to the one used by the community nursing team, which did not facilitate communication between GPs and community nurses. We found that this was also the case with the out-of-hours provider, which presented further communication issues. In locations where community nursing staff accessed electronic patient records through GP systems, GPs decided their access rights, which could be limited to nursing information only and therefore could exclude medical information. This could cause gaps in the referral information available to the community nursing team, or delays in the team accessing information.
- Some community-based staff had difficulty accessing the trust's computerised records management system due to shortages of computer equipment. We found that not all community nursing staff had access to laptops or similar devices to facilitate the recording of patient data. During our visit, some staff expressed concerns to us about the shortage of computers and printers and about the arrangements for repairing computer equipment. Difficulties were experienced especially at times of peak use, when typically up to 10 staff required access to the computer system but only four or five desktop computers were available.
- Staff in a focus group gave us examples of issues they had encountered in gaining access to shared care records, which potentially presented some risk to the safe care of patients as well as to the safety of staff. Issues relating to the provision of IT equipment differed in the various areas within community services. Some staff said that they had adequate equipment, while others expressed concerns about the capacity of current IT equipment and were unclear about the timescales for resolving this issue. Overall, staff felt that the steps being taken to resolve IT issues represented an improvement.

Cleanliness, infection control and hygiene

- We observed staff during home visits and clinic sessions and saw that correct infection control techniques were followed. Staff demonstrated that they had a good understanding of infection prevention and control. Clinical staff we observed followed guidelines relating to hand washing and being bare below the elbow. Staff

cleaned their hands and used hand wipes and hand gel before and after they provided care. We observed that gloves and aprons were used appropriately. A patient with methicillin-resistant Staphylococcus aureus (MRSA) was visited at the end of the day. We were informed that in a clinic setting the patient with MRSA would be seen last.

- Community locations we visited appeared visibly clean and there was evidence of regular adherence to cleaning schedules. Equipment was cleaned after use and an "I am clean" sticker was used. The clinic environment was clean and tidy and sharps boxes were available. The cleaning schedule and clean hands guidance were displayed on staff noticeboards.
- Mandatory training for staff included infection control.
- We reviewed the community services monthly performance report dashboard for January 2015, which included the incidence of bacteraemia from April 2014 to March 2015. A total of 11 incidents in community settings had been reported over 12 months.
- Each community nursing team included an infection control link nurse. The link nurse's role included attending infection control meetings and providing feedback to their team.
- Cleanliness and infection control audits were undertaken to identify risks and issues and action plans were prepared. Any lapses were identified and action taken. Hand hygiene audits were completed monthly. However, at one location we visited, nursing staff did not appear to appreciate the significance for patient safety of requiring full compliance with audits, and were not aware of their team's level of compliance with audit requirements.

Lone working

- The service had a lone working policy in place. This included procedures to reduce the risks to staff working alone. The policy was available on the staff intranet.
- Staff had previously been issued with emergency contact devices to alert colleagues if they encountered a situation in which they were vulnerable, but staff informed us that the devices had now been withdrawn. Lone worker security cards, which incorporated GPS positioning, were in the process of being issued to staff. Security risk assessments were completed for locations where staff might need to work alone, particularly in the evenings. The community site risk assessment identified risk areas and actions to reduce risk. Lone working risks were included on the agenda of the weekly multidisciplinary team meeting.
- A paper-based lone visit sheet and accompanying red star folder could be used to identify addresses that were considered to represent a higher risk to staff working alone. Staff then arranged to visit these locations in pairs.
- We spoke with staff who mainly worked alone in community settings about the service's lone working procedures. Staff working from community locations were supported using informal procedures within the team. In some locations, staff were prompted to stay in touch with colleagues by mobile phone and text message and to inform them of their whereabouts. We found that these arrangements, including buddying, were applied quite loosely in some teams we visited. Staff expressed mixed views as to the effectiveness of these arrangements in supporting their safety. Staff in some teams felt that they worked effectively, whereas others expressed concerns about some of the areas they worked in, particularly in the evening and at weekends. They informed us that buddying and other informal procedures were not working, and said that staff were reluctant to take responsibility for receiving calls from colleagues at the end of their shift.
- An additional concern mentioned to us by staff was the lack of network coverage in some rural areas, which meant that the use of mobile devices could be unreliable. We spoke with a member of staff who usually worked in isolation and who felt that lone working and the risks associated with it were not taken seriously enough by the service. Their concerns had been escalated, but the staff member did not feel that they had received an appropriate response. Staff in a focus group stated that some, but not all, staff had lone worker devices to support safety. Staff felt that the lack of lone worker training was an issue that affected their safety.

Mandatory training

- We reviewed the trust records for training. The records were broken down by service and location and showed the percentage of mandatory training completed by type of training. For community services, mandatory training participation rates for all modules across the service (with one exception) fell below the trust

minimum compliance target of 75%. Fire safety awareness training was above the 75% compliance level. Senior staff told us that some parts of mandatory training were no longer considered essential for community-based staff.

- We discussed mandatory training with staff at the locations we visited. Locally maintained records for members of staff in community locations included the mandatory training they had attended. Training information we reviewed presented a mixed picture. For some locations, staff had completed mandatory training, or arrangements had been made for them to attend training. For these locations, staff had not experienced difficulties in accessing training.
- We reviewed individual training records for several members of staff. In some community locations, we saw that a training board was displayed and reflected this information, although it did not include overall percentages of training completed. Where required training was overdue, this was highlighted. We found that each team manager was informed of the level of training compliance for their team. Staff responsible for planning and delivering mandatory training accessed trust-wide training records to review gaps so that staff could be reminded to attend planned training.
- We were informed that access to e-learning was available through a training hub. Staff could review what training they were due to attend and could book courses. However, we found that in some locations staff encountered difficulties in accessing this. During our visit, staff in one team told us that they were unable to attend training, including statutory and mandatory training, or undertake e-learning due to time constraints. Other staff we spoke with confirmed that no time was allocated to mandatory training. Staff also told us that previously they could access e-learning from home, but this facility was no longer available.
- Staff in a focus group told us that the availability of the electronic learning hub had helped significantly with access to training, although it was still to be rolled out to all teams. Some teams continued to experience issues relating to the availability of computer equipment to access training. Other staff we spoke with stated that access to e-learning through their office computers was good. However, they expressed the view that mandatory training was not community focused. Some nursing courses were unavailable or had waiting lists, for example nutrition, manual handling and conflict resolution training.
- Staff at one location we visited were unaware how to access e-learning. At another location, training records we reviewed for two members of staff showed that mandatory training was overdue by five years. One staff member had been due to attend a full day of training arranged in February 2015 to cover most of this training but was informed that it had been cancelled due to staff shortages. The training was subsequently rearranged for August 2015. Staff also explained that they were expected to attend the acute hospital in York for some aspects of their mandatory training, but this was often impractical for rural-based staff. We were informed that these concerns had been escalated to managers.

Assessing and responding to patient risk

- The service was proactive in responding to identified risks. Community nursing staff were able to describe examples of escalating their concerns when a patient's condition deteriorated. The service used a deteriorating patient policy that was linked to the quality and safety dashboard. Staff described the arrangements for handovers between team members, which occurred daily.
- We spoke with staff based in several community locations who demonstrated a sound awareness of key risks to patients, including risks of pressure damage and falls. Depending on the risks identified, further support was arranged for the patient, such as the supply of additional equipment, or referral for further specialist assessments. To address the risk of falls identified for patients in the community, nursing staff at one location told us that they had recently been given the right to access a range of community-based services including physiotherapy, occupational therapy, orthotics and podiatry.
- Community services maintained a risk register of identified risks in community settings. The patient's initial assessment included an assessment of environmental risks. We saw that practitioners in therapy services also completed the risk register. For example, where patients were assessed as presenting a higher risk to visiting staff, their address was identified using a red star folder, and staff arranged to support

colleagues making these visits. Staff were able to give examples of patients who were assessed as higher risk and explained the steps taken to mitigate the risk, for example by arranging for the patient to visit a clinic. However, some senior staff we spoke with felt that the local arrangements for risk management lacked robustness, as the red star folder system was not being used consistently.

- With the patient's permission, we accompanied nursing staff on a visit to a higher-risk patient and observed the appropriate delivery of care and the steps taken to mitigate risk by the two members of staff making the visit. We also accompanied therapist staff during two visits to patients. We saw that assessments included patient safety, and the therapist observed specific risk areas in the home and advised the patient on mitigating these risks in an appropriately sympathetic manner.
- At the first visit, a prevention of pressure ulcer assessment was included in the patient's initial assessment of risk within the care plan. Assessments were completed for each patient and included skin integrity, nutrition, falls risk, pain assessment and living environment. We saw that the assessment tools used were located mainly within the nursing record.
- The trust had prioritised the need to reduce the development of pressure ulcers for patients in their care. Pressure ulcer reduction plans included patients in community care and we were informed that the prevalence of harm from pressure ulcers was decreasing. A pressure ulcer report was prepared weekly by the district nursing service. The district nursing team shared information about the management of risks relating to pressure ulcers with other teams including tissue viability and dermatology. However, at one location we found that, when the pressure ulcer risk assessment tool identified potential safety issues, this information was not shared with therapy staff.
- We reviewed the minutes of the community pressure ulcer prevention and management group, which met monthly with representatives of the district nursing and tissue viability teams. We saw that a pressure ulcer risk assessment tool was used and actions taken were audited. A leaflet providing advice on preventing and treating pressure ulcers had been prepared by the tissue viability team. Staff we spoke with told us that attending the pressure ulcer group was time-consuming, and they questioned whether the current review process was disproportionate in some situations.
- NHS Safety Thermometer data issued by NHS England showed that the trust had been above the national average for slips, trips and falls since October 2014. Community health services accounted for 15% of these incidents. Community nursing staff were undertaking a pilot using a falls screening tool; if a risk of falls was identified, they would consider a referral to an occupational therapist or physiotherapist. We found that the falls team had recently been discontinued and an advanced clinical specialist had taken on a trust-wide role with a focus on falls prevention; this included a six-week programme for patients at risk of falls delivered in a clinic setting.
- Staff described to us a further example of managing risk: the use of "Rescue packs" for some patients with long-term conditions. The rescue packs were used to help maintain these patients at home and were available on repeat prescription.
- Staff in a focus group told us that in situations where care responsibility was shared, they had concerns about access to records to ensure that all staff involved were informed when a patient was a risk, which included those patients who posed a risk to staff.

Staffing levels and caseload

- The service conducted a capacity and demand audit review during 2013 to assist in planning staffing levels and caseloads. The review of workload and staffing levels included both community nursing and therapy services and took account of budgeted and actual staff establishment, vacancies, sickness levels and annual leave for each community team within each locality. Staff establishment and grades required to meet incoming referrals were estimated; the estimates reflected direct and indirect patient care and travelling time. Monthly referral information included new patients and reflected the average time spent with each patient by each grade of community staff.
- Staff in a focus group for managers told us that staffing levels were historical and based on professional judgement. They confirmed that a staffing tool was not currently used for community services, but we were informed that a caseload and staffing review tool was in development, based on national guidance. Managers acknowledged that there were challenges with workforce planning and recruitment, particularly for

community services. Some areas, for example Scarborough and Ryedale, faced particular difficulties with recruitment. We were informed that staff diary sheets were actively reviewed to monitor caseloads.

- In response to concerns identified by analysing the national Hospital Standardised Mortality Ratios, which are available through NHS England, the executive team informed us that action was being taken to reduce variations in staffing levels that occurred particularly at weekends.
- The trust submitted data to support our inspection which showed that absence and sickness rates for community services in 2013/14 were 3%; this was lower than the overall trust absence rate of 3.6%. However, the average monthly absence rate showed an increasing trend for the period from November 2013 to February 2014 and this trend had been repeated between August 2014 and October 2014. Sickness absence rates varied considerably between teams, with a maximum of 8.3% for Scarborough. One team we visited stated that there were issues with staffing due to sickness.
- The trust submitted data which showed that the staff turnover rate for the five months from July to November 2014 was higher than that for April 2012 to March 2013. The turnover rate for community services management, intermediate care and fast response and Malton and Scarborough community services for July to November 2014 was significantly higher than the average for this service. Whitby community services recorded the highest vacancy rate. Community management, intermediate care and fast response all recorded an above average vacancy rate. The trust data showed that the vacancy rate in adult community therapies was 6%.
- We found a mixed picture in the community teams we visited. Several teams told us that they were not experiencing problems with staff shortages or recruitment and no agency or bank staff were used. We found that community nursing teams had a typical caseload of 10 patient visits per day, with a maximum of 15 visits. Several teams told us that they felt this was manageable. The use of bank or agency staff was discouraged. For unplanned absences, all off-duty staff were contacted. Staff frequently started early and worked late to cover absences and, when workloads demanded it, they handed over their remaining visits to evening services.
- One team told us that bank staff were used to cover absences and that visits to higher-risk patients were prioritised. Several other staff expressed concerns about increasing workloads, difficulties with recruitment, and the skill mix of staff, particularly the ratio of qualified staff to healthcare assistants, who were being asked to undertake more complex care. To assist teams facing particular workload pressures, staff were rostered to move between teams.
- During our visit, we received information from staff in one area who expressed concerns about increasing workload pressure, the high turnover of staff and difficulties with recruitment. Staff were concerned that caseloads were being merged to form larger caseloads, although there were no extra staff. They said that most staff worked extra hours, unpaid, and often worked without breaks. This reflected our findings when we spoke with some staff. However, nursing staff were unable to demonstrate high numbers of visits compared with numbers in other trusts. We asked staff to provide specific examples where they felt that patient safety may have been compromised because of staffing issues, but they were not able to do so.
- Staff in a focus group told us that there had been real improvements in the recruitment of healthcare assistants in their locality. Therapy staff felt that they were not able to see all the patients who should be referred to them. Specialist nursing staff were concerned that they had been asked to cover staff shortages in a community hospital inpatient setting when they were not trained for this role. We were informed that this had occurred on one occasion. Nursing staff expressed concern about staff resources available to support the rapid response team. AHPs were concerned that the service had no administrative support. All members of the group felt that they went above and beyond the requirements of their role by working more hours than they were contracted to work in order to ensure that patients were safe.

Managing anticipated risks

- Community health services managed foreseeable risks and planned for changes in demand due to seasonal fluctuations; this included disruptions to the service due to adverse weather. We found that staff in the service were generally aware of emergency plans, including winter plans to meet the needs of vulnerable patients during periods of severe winter weather or in other emergency situations such as power cuts.

Requires improvement

Are services safe?

- Staff were generally aware of operational meetings for emergency planning. Some members of staff were involved in these meetings. Community staff we spoke with were aware of emergency arrangements.
- Staff in a focus group for community and specialist nursing staff told us how they were involved in emergency planning and contingency plans for adverse conditions, including winter planning arrangements. Planning included the use of snowbound staff to visit patients in the area where they lived and who were within walking distance. Staff with off-road vehicles were allocated to provide access to patients in some rural areas. An independent rescue service with 4x4 vehicles was used during severe weather, and essential visits were prioritised. This was confirmed by other staff we spoke with. Vulnerable patients were issued with a rescue pack if they required one; this could also be ordered using a repeat prescription. Community matrons were fully involved in these arrangements. However, one team we spoke with was unaware of arrangements to use 4x4 vehicles in adverse weather.
- Community nursing teams had systems in place to facilitate cover between neighbouring district nursing teams within the primary medical group, and also to use staff from a wider geographical area in some circumstances. Cooperation arrangements were in place between district nursing teams to reduce potential problems for service delivery following significant team illness or loss of staff for other reasons.

Major incident awareness and training

- Community services had contingency plans in place to respond to major incidents. A business continuity plan for use following a significant major incident or emergency was used in conjunction with the incident response plan. The service's plans included action cards, aide-memoires for guidance, and emergency contact information. Recovery plans that were in place included responses to specific scenarios at directorate, service, team and site level.
- The business continuity plan was intended to support staff in coordinating response and recovery and to enable the service to fulfil its responsibilities under the Civil Contingencies Act 2004. The plan set out the trust's approach to preparing for a range of emergency situations and included information that staff were expected to be aware of, particularly the arrangements set out on action cards in the incident response plan.
- Locality managers were included in planning for responses to major incidents. However, we found that not all community matrons or community nursing staff were familiar with these arrangements.

Good

Are services effective?

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

Summary

Community services used guidance from the National Institute for Health and Care Excellence (NICE) and The Royal Marsden Manual of Clinical Nursing Procedures. Policies and best practice guidelines were used to support care and treatment. Patient group directions (PGDs) used in community services were based on national guidance for treatments. Staff understood their roles and responsibilities in the delivery of evidence-based care. A recognised assessment tool supported by national guidance was used to support the review of patients with pain symptoms. Nutrition and hydration assessments were usually completed, and patients were referred appropriately to specialist services.

Community and specialist nursing staff received annual appraisals and staff development. Training for qualified nursing staff and healthcare assistants was supported, including through a learning hub, and mentoring arrangements were in place for student nursing staff. A competency framework for therapy staff was being implemented from April 2015, supported by peer supervision. Not all locations were aware of clinical supervision arrangements. Formal clinical supervision was not in place for therapy services.

Community therapy services staff had regular contact with community nursing teams. For more complex patients, multidisciplinary team meetings were held. Specialist nursing staff and health visitors had good relationships with primary care, including GPs and practice nurses. Specialist nursing staff had experienced poor communication with hospital medical and nursing staff in relation to the patient pathway, although inpatient services and specialist nursing teams were working collaboratively on protocols to improve communication.

Information was available for staff on the trust intranet to support practice. Patients were asked for their consent appropriately and correctly. Most staff had an understanding of the Mental Capacity Act, and this was demonstrated in practice.

Limited audits of community services had been undertaken to review outcomes for patients of the care and treatment provided. The service had an audit programme for 2014/15, although this did not include a clinical audit plan. The NHS Safety Thermometer was completed monthly, although staff did not receive analysis of or feedback on the results. Not all staff were aware of key performance indicators used in the service.

Detailed findings

Evidence-based care and treatment

- Community services used guidance from NICE and The Royal Marsden Manual of Clinical Nursing Procedures, which were available electronically. We saw references to and use of national guidelines within a number of services. Policies and best practice guidelines were used to support the care and treatment provided for patients. Specific pathways and guidance were used for certain long-term conditions; staff accessed this information on the trust intranet.
- A nursing and midwifery strategy implementation plan for 2014/15 was in place and included community services. The nursing and midwifery strategy included priorities and action plans to achieve high-quality nursing care for the next three years. The implementation plan outlined current workstreams and priorities and was monitored to demonstrate progress to date.
- PGDs used in community services were based on national guidance for treatments. A combined PGD database was available on the staff intranet. We reviewed several PGDs used in the service. A PGD questionnaire was used to test the competence of staff prior to using PGDs.
- We found that 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, for example those on infection control procedures. Patients' assessments were completed using templates available on the trust's computer system; these followed national guidelines for measuring harm as reflected in the NHS Safety Thermometer.

Good

Are services effective?

- Community nursing staff we spoke with understood how NICE guidance was applied in their clinical practice. We found that the physiotherapy and occupational therapy teams followed evidence-based guidelines for treatments; this was confirmed by documents we reviewed. When we observed staff administering care to patients, we saw that assessment guidelines were used correctly. We observed that the use of pathways and guidance was followed when staff administered care and treatment and during handovers.
- We found that community nursing teams followed NICE guidance when administering care that involved skin viability or pressure ulcer management and avoidance. Staff referred patients to the tissue viability service, dermatology or other services as appropriate. Community nursing and tissue viability staff followed wound formulary guidelines for wound dressing and care that reflected NICE guidance. Nursing staff used the standards to determine whether to request additional support to manage potential pressure ulcers and, in particular, to decide whether to request specialist tissue viability nursing staff or specialist equipment. We observed an example of the use of the pressure ulcer risk assessment tool that was used to inform treatment plans.
- A further example we observed was for a patient with a hip fracture who was at risk of falls. We saw that staff followed evidence-based practice effectively. The respiratory team used local guidance that drew on NICE chronic obstructive pulmonary disease (COPD) guidelines for pulmonary rehabilitation. Study days were used for the respiratory services team to inform staff of new guidelines. Updates to guidance were available through the British Lung Foundation and a practitioner-led Yorkshire respiratory network was being set up to provide peer support.
- Community nursing staff in a focus group shared some of their practical concerns about implementing change in specialist practice, for example tissue viability. Information was disseminated throughout community services electronically, including on the staff intranet and via the training hub. Staff had some concerns that the impact of this approach could vary between teams.

Pain relief

- A recognised assessment tool supported by national guidance was used to support the review of patients with pain symptoms. We found that care plans indicated whether a review was required, although a pain-scoring system was not used in all parts of the service.
- Pain management plans were discussed with the patient to ascertain their pain levels and to provide advice. Pain and discomfort were included in the patient's basic assessment, which nursing staff completed with the patient's responses, including to the impact of pain. We observed that pain was assessed as part of the patient's initial assessment and pain relief was offered in conjunction with the patient's GP. Our observation of staff administering care and treatment and our review of patient records confirmed that patients were assessed appropriately for pain symptoms. Patients received treatment that applied pain relief effectively. However, other staff we spoke with told us that patients who contacted the service during the evening or overnight could have a wait of up to two hours for pain relief.

Nutrition and hydration

- Community services used a recognised assessment tool supported by national guidance to review the need to support the patient's nutrition and hydration.
- When we observed nursing staff administering care, we found that a nutrition and hydration screening tool was completed at the patient's initial assessment. Nursing staff asked patients about their diet and we observed assessments being completed appropriately. However, with some patients staff focused on either nutrition or hydration, not both, and assessments were not completed in every case. In some teams, staff told us that they would use the screening tool if there were concerns, and we saw that the tool was completed.
- Community and specialist nursing staff referred patients to a dietician if additional support and advice on appropriate treatment was required, for example for diabetic patients. If nursing staff found significant weight loss, they would speak to the GP about a possible referral to a dietician.
- Information about nutrition and hydration was included in information for patients. For example, a leaflet issued by the tissue viability team included a section on "A good diet".

Good

Are services effective?

- Training in nutrition and hydration was not available consistently for staff. We were informed that there was a waiting list for the nutrition course.
- The specialist diabetes nursing team at one location told us that a full-time specialist dietician was on site. This meant that there was good access to the service, and it had raised awareness. Their involvement in the Think Glucose campaign, for example, had helped ensure that patients' meals and diabetic medication were given at the same time, as appropriate.

Approach to monitoring quality and outcomes of care and treatment

- Limited audits of community services had been undertaken to review the outcomes for patients of the care and treatment provided. The trust had an audit programme for 2014/15, although this did not include a clinical audit plan. We reviewed the results of a selection of audits completed in community services and discussed the outcomes with staff. Audits, for example of documentation, were undertaken monthly at some locations we visited and included conclusions and recommendations for the service. We saw that an action plan had been prepared for community nursing documentation in February 2015.
- At one location we found that an audit of patient notes was undertaken every six weeks and was supported by peer review. Learning was identified and we saw evidence of learning for six months, with areas of good practice and areas of improvement noted. The audit of community district nursing medication documentation undertaken in October 2014 included a plan with actions to be completed by April 2015. Staff at one location told us that they undertook audits occasionally, but we were unable to review further evidence of this.
- A primary care setting in Acomb used a range of audits effectively to support improvements in practice. For example, a record-keeping audit was undertaken each month using a set of notes selected randomly that was examined with the nursing team. The audit had been taking place for six months and was an example of good practice.
- AHPs, for example in physiotherapy and respiratory services, completed end-of-year audits to ascertain whether standards had been met. Community district nursing documentation, the administration of medication, and the use of the pressure ulcer risk screening tool were audited. The NHS Safety Thermometer was completed monthly in community services, although staff did not receive analysis of or feedback on the results.
- For AHPs, we found that end-of-year reports were prepared for therapy staff using therapy outcome measures for occupational therapy and physiotherapy, adapted from national guidance. However, we were unable to review the outcome reports. The service manager had developed a local performance monitoring tool for therapy referrals, waiting times, targets and performance that analysed demands on the service. The tool used standardised outcome measures, for example the elderly mobility scale. The tool helped in developing action to respond to workload demands, for example winter pressures, and supported service improvement. Specialist nursing staff at one location told us that they completed annual audits of documentation and reviewed prescribing decisions with a medical mentor. Specialist nurse staff at another location told us that they were not aware of key performance indicators used in the service.

Competent staff

- Community and specialist nursing staff received annual appraisals and staff development, although appraisal data received from the trust was incomplete. For those community staff groups for which complete data was received, the figures showed that 80% to 95% of staff in each team had completed their personal development review. This was confirmed during our inspection by a review of local data in the locations we visited, except in the case of one location where senior staff had only recently been appointed and most appraisals were overdue.
- We were informed that all specialist therapy staff had received annual appraisals. Staff we spoke with felt that appraisals were valuable as a two-way process to explore ideas for improvement, as well as future goals. Nursing staff who conducted appraisals accompanied staff on visits to assess their performance prior to appraisal.
- Training for qualified nursing staff and healthcare assistants was supported and was discussed in annual appraisals. Some staff we spoke with felt that a wide range of training was available to them. Staff spoke positively about the learning hub, which enabled them to access training updates. Staff received reminders

when training became overdue. We spoke with several staff who were supported to attend external training and they spoke appreciatively of the trust's support for this. Staff in a focus group gave examples of when they had been given personal development opportunities and stated that this had had a positive impact on service effectiveness.

- Mentoring arrangements were in place for student nursing staff, who told us that they felt well supported. A register of mentors was maintained and qualified staff involved with mentoring attended an annual mentor update. However, we spoke with nurse mentors in one team who said that they felt under some pressure because of a shortage of mentors and the lack of availability to undertake mentorship training.
- Specialist therapy staff told us that online training was available through the training hub, but they had only limited external training opportunities. Some staff undertook training and cascaded what they had learned to others. In-service and inter-trust training was used.
- Staff attended learning events to support their competencies, for example in pressure ulcer care. A personal development day was available for independent nurse prescribers, who also received group coaching, peer support and support from GP practices.
- At one location, community nursing staff we spoke with felt supported through mandatory training and appropriately qualified for their role. At another location, nursing staff told us that they had received no training for about five years, but training had recently started again using an action learning set approach; staff described this as effective. We were not able to review a record of these meetings.
- Healthcare assistants we spoke with confirmed that they worked within their competency, and we saw that this was the case during our observation of visits to patients. Healthcare assistants were supported to undertake an extended range of tasks; these included basic wound care and, for more stable patients, administration of insulin, catheterisation, and bowel care. Healthcare assistants received training to undertake these aspects of their role.
- For community therapists, we found that a competency framework was to be implemented from April 2015, supported by peer supervision. For example, for generic assistants working in the therapy team, we found that competency training in occupational therapy and physiotherapy was being introduced as a rolling three-month programme of in-service training for qualified staff.
- Senior nursing staff attended a monthly management supervision meeting with the locality manager. Community nursing staff at some locations we visited provided examples of both the formal and informal clinical supervision available to them. We reviewed the format for peer supervision groups, which arranged to meet every six to eight weeks. Not all locations we visited were aware of clinical supervision arrangements.
- Formal clinical supervision was not in place for therapy services, and we found that it had not taken place for some time. The specialist nursing team did not include trained clinical supervisors although we found that specialist therapy staff were allocated protected time for teaching therapy colleagues. We were informed by senior staff that group clinical supervision had been introduced recently, along with one-to-one management supervision, which was to take place every eight weeks. One-to-one meetings for staff were available on request. A specialist nurse confirmed in a staff focus group that they had a one-to-one meeting arranged. We found that specialist nursing staff operated a buddy system, which included community matrons. Consultant medical staff also provided support for specialist nurses. Staff in a focus group confirmed that they had attended both the group sessions and one-to-one peer support.

Multidisciplinary working and coordination of care pathways

- We found that community therapy services staff had regular contact with community nursing teams. For more complex patients, multidisciplinary team meetings were held at the appropriate community hospital weekly and were attended by a medical consultant, social workers, physiotherapy, occupational therapy and other specialist nursing staff, for example for diabetes. Multidisciplinary meetings were also held monthly for higher-risk patients with long-term conditions; these could also be attended by the patient's GP. We reviewed examples of the minutes of these multidisciplinary meetings.
- At several locations we visited, specialist nursing staff, for example diabetes service staff, told us that they had good relationships with primary care, including GPs and

practice nurses. GPs we spoke with described having visible and trusted communication with community nurses and regular meetings with health visitors. For community nursing teams co-located in general practices, daily multidisciplinary meetings were held to prevent and follow up admission and to review discharges, for example for patients who had been admitted the previous day. Community nursing staff did not routinely attend these meetings, but they received a written record of the meeting, which we saw. At another location, community therapy staff told us that the GPs' understanding of their service needed to be improved. Therapy staff were linking with a new primary care group to facilitate this.

- Staff followed up opportunities to deliver training in primary care settings. Specialist respiratory staff worked with community matrons to support training for nursing staff in care homes in their area. We found that there was positive feedback from staff who attended this training.
- Community nursing staff described positive experiences of multidisciplinary working. Specialist nurses, for example for diabetes care, held weekly meetings with the community nursing team to discuss patient concerns and to arrange joint visits. We observed community therapy staff during two visits to recently discharged patients' homes.
- We saw examples of multidisciplinary working: for example, there was discussion with a respiratory nurse about care and support and planned feedback to a physiotherapist about the patient's condition. However, therapy staff at one location said that no social workers or occupational therapists were co-located, which presented barriers to multidisciplinary working.
- Community matron and nursing staff described multidisciplinary working involving the local authority. They received prompt responses to urgent social services referrals. At one location, staff described having close working relationships with the local authority, which also involved specialist nursing staff. At two further locations we visited, staff told us that they had positive links with specialist therapy staff and with social services, although this depended to some extent on the individual social worker and requests for assessments could take some time. At another location, community nursing staff described having limited liaison with social care, particularly for patients with long-term conditions. However, general practice nurses were becoming more involved in providing care and support for these patients.
- Specialist nursing staff told us that there had often been poor communication with hospital medical and nursing staff with regard to the patient pathway. However, they also told us about improvements they had experienced in these relationships. Inpatient services and specialist nursing teams were working collaboratively on protocols to improve communication. Therapy staff had also developed new ways of working with inpatients to support collaboration.

Availability of information

- Information was available to staff through the trust intranet to support practice. Staff briefings were available through the intranet, with links to new policy documents. Live information about patient care and treatment was available, which also provided access to external internet sites.
- A staff newsletter and bulletin were emailed to staff monthly. Staff we spoke with told us that they were kept well informed by the trust and felt supported through emails and other methods of communication, including face-to-face meetings with locality managers; staff felt that the latter were structured and focused. Staff told us that they were kept up to date with any changes and given plenty of notice. They also felt they communicated well within their team. However, staff we spoke with at one location felt that little useful information was communicated to them by the trust. At another location, staff felt that finding policies on the intranet could be time-consuming, although they said this might have been due to policies being updated at the time.
- A patient safety newsletter prepared by the trust was cascaded through community services. In community locations we visited, we observed that a communication board was displayed in staff areas with trust-wide information for staff, including training details. The chief executive briefing and staff newsletter were displayed on staff noticeboards.
- At one location we visited, we saw that nursing staff had developed a directory of services located in the surrounding area for use by staff. The information

included community health services internal and external to the trust, health and community adult services, respite centres and other community health-related services.

Consent

- Patients were asked to give consent appropriately and correctly. 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 it was obtained and completed correctly.
- Where nursing staff used photography to obtain a record of the patient's condition and symptoms, this was done with the patient's written consent at the start of their course of treatment and at two- to three-week intervals.
- The Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) were included in mandatory training. Most staff we spoke with demonstrated a clear understanding of the MCA, of their responsibilities and of DoLS procedures. We saw that information about the MCA and a step-by-step guide to capacity assessments were displayed on staff noticeboards. However, at one location staff were unclear about the MCA and were unsure about the training they had undertaken. Some staff had experienced difficulties in accessing MCA training.
- We reviewed several instances where the patient lacked capacity and the service acted in the patient's best interests; in these cases, the relevant procedures had been completed correctly. A mental capacity assessment was undertaken if the patient refused any treatment, or if the nursing staff had a concern that the patient might not have the capacity to consent.

Good

Are services caring?

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

Summary

Patients and relatives were treated with respect, dignity and compassion and we saw caring, compassionate care being delivered. Staff were seen to be very reassuring towards patients, their relatives and other people. Staff had a good understanding with patients. Staff respected patient confidentiality in discussions with patients and their relatives and in written records or other communications. Patients and their families we spoke with were very happy with their care and the service they received.

Staff demonstrated good communication skills during the examination of patients, with clear explanations, and they checked the patient's understanding. Staff explained what the patient could expect to happen next and gave details of likely and possible outcomes. They answered any questions from the patient directly. Where appropriate, patients were involved in their own care plans. Patients were given information leaflets for new regimes of care to support their understanding.

Staff provided emotional support to patients and relatives. Staff were aware of the emotional aspects of care for patients living with long-term conditions and provided specialist support for patients where this was needed. Patients requiring it were given time to discuss their emotions and were offered support.

Nursing staff confirmed that they worked with patients, family members and carers to support their self-care, although they were able to provide only limited practical examples of this. For therapy staff, the patient's self-care and self-management provided a focus for the visit and were integral to the care and treatment the patient received.

Detailed findings

Dignity, respect and compassionate care

- During our visit we saw that patients and relatives were treated with respect, dignity and compassion and we saw caring, compassionate care being delivered. Staff were seen to be very reassuring towards patients, their relatives and other people. Staff had a good understanding with patients.
- When delivering care and treatment, staff respected patient confidentiality. Confidentiality was maintained in discussions with patients and their relatives and in written records or other communications.
- During our inspection of the different services, we found that staff used an approach that was consistently appropriate to the setting and demonstrated compassion and consideration for the patient.
- We observed care and treatment being delivered by community nursing and specialist nursing staff to patients in several home settings. Care was delivered sensitively and effectively in a caring, compassionate and appropriately responsive way. Staff respected and maintained the patient's dignity.
- Our observation included initial visits to two patients previously unknown to the service. Nursing staff immediately established a good rapport with the patients and demonstrated compassion while maintaining the patients' dignity. We saw that staff were very knowledgeable and professional in their approach. Care was well received by patients and their families.
- We observed care and treatment being delivered in a community location and during home visits by therapy staff. We found that staff ensured the patients' privacy and dignity were maintained. Discussions with patients were conducted with appropriate sensitivity to their needs. Patients were very positive about the quality of care they received.
- Patients and their families we spoke with were very happy with their care and the service they received. They spoke highly of staff. They said that staff were helpful and always treated them with dignity, respect and compassion. They had no criticisms at all of the district nursing service.
- We observed that letters and comment cards received from patients were displayed in community locations we visited. Consistently positive comments were made about the district nursing service, expressing gratitude for the level of service provided. Community nursing staff in a focus group shared examples of feedback they had received from patients that illustrated patient satisfaction with the service.

Good

Are services caring?

Patient understanding and involvement

- We saw that staff demonstrated good communication skills when they examined patients. Staff gave clear explanations and checked the patient's understanding. We observed that staff appeared to understand the patient's symptoms well and related the injury to the patient's occupational needs and function.
- Staff explained what the patient could expect to happen next and gave details of likely and possible outcomes. They answered any questions from the patient directly. Subsequent visits were arranged if more information was required to support and involve the patient in their care and treatment.
- We observed home visits by community nursing and therapy staff. Where appropriate, patients were involved in their own care plans. This sometimes required only a simple explanation for the patient to become involved. Patients felt ownership of their records and appreciated being involved in their care planning. Staff were not prescriptive. Patients were involved in decisions about the provision of their care, were asked for their opinion, and were given a choice about recommendations for care and treatment. Staff were able to give other examples where full explanations of their care had been given to the patient to support their wish to be involved.
- Nurses used their relationship with patients and carers to impart information to support the patient. Nursing staff told us how they built in enough time for visits to ensure that the patient did not feel rushed. Staff talked with patients about their priorities in an empathetic way. They took time to ask whether the patient understood the information. This applied to student nurses and healthcare assistants as well as qualified community and specialist nurses. Staff fully engaged the patient in their care. Staff told us that patient education was a key feature of the service.
- For patients who were able to visit a community location, regular clinics were held, for example for wound care. These provided a further opportunity to support the patient's understanding of their condition and to exchange information with other patients and carers.
- Patients and their families said that they felt supported and helped by the nursing staff who had visited. This was especially true where the patient was visited by the same member of staff; in these cases, patients felt that continuity of care had improved and this supported their understanding.

Emotional support

- We observed staff providing emotional support to patients and relatives. Staff were aware of the emotional aspects of care for patients living with long-term conditions and provided specialist support for patients where this was needed.
- Staff we spoke with were able to give current and recent examples where they provided emotional support for patients and their relatives.
- A bereavement service was provided. We saw that a brochure was available with helpful information for people who were recently bereaved.
- When we accompanied staff making home visits, we observed that staff were sensitive to emotional issues.

Promotion of self-care

- At locations we visited, we asked community nursing staff about working with patients to promote their self-care. Nursing staff confirmed that they worked with patients, family members and carers to support this aspect of the patient's care, although they were able to provide only limited examples of this.
- When we accompanied therapy staff making home visits to patients, we observed that the patient's self-care and self-management provided a focus for the visit and were integral to the care and treatment the patient received.
- The therapy service supported exercise regimes for patients in community clinics. At one location we visited, we saw a community exercise therapy group in which eight patients participated. We spoke with patients who told us that they enjoyed the activities provided by therapists aimed at promoting self-care. Patients appreciated the support provided by physiotherapist and occupational therapy staff and the quality of care they received.
- At one location we spoke with nurse specialists involved in promoting the Dose Adjustment For Normal Eating (DAFNE) programme to support patients in managing type one diabetes. The DAFNE programme aimed to provide patients with the skills necessary to estimate the carbohydrate in each meal and to inject the right dose of insulin. The programme included an annual external audit to assess the impact of training on

Good

Are services caring?

patients. However, staff told us that the audit showed only a low level of compliance. Diabetes nurse specialists were also involved in promoting a national 'Think glucose' campaign to improve patient experience and self-management of their condition.

Good

Are services responsive to people's needs?

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

Summary

Patients were assessed promptly for care and treatment and referrals were triaged. Any patient deemed to be an urgent priority was seen very promptly, usually within five working days. Community services used a single point of access to help ensure that patients got the right care at the right time and, where possible, avoided being admitted to hospital. A refinement of the prioritisation criteria was identified as a key development need. The service was a national pilot site for the development of community hubs to support the delivery of care nearer to home. Two community hubs, based at Malton and Selby, had been established to support seven-day assessment for residents of care homes; this enabled early intervention and reduced the need for crisis intervention.

Managers and staff worked with local commissioners of services, the local authority, other providers, GPs and patients to coordinate and integrate pathways of care. For patients who required support for mental health or social care needs, arrangements for care and treatment were facilitated with mental health teams or social services.

Specialist teams provided services in the community that met patient needs closer to home and were accessible, particularly in rural parts of the area. The multiple commissioners covering the large geographical area had presented some issues in planning a consistent strategic direction for the service, as commissioners had different requirements. The service had taken steps to rationalise this so that arrangements were more structured and supported joined-up care for the patient. The single point of access, operated through another trust, did not currently include therapy services. There was currently no overnight or weekend community nursing service in Scarborough and Ryedale, although this was planned.

We found examples of communication with hard-to-reach groups in the Scarborough area that had been developed by community therapy services in response to the needs of the local community, including homeless patients and patients who used substances. Trust information showed that less than half of community and therapy services staff had received training in equality and diversity in the previous 12 months, although staff we spoke with had received this mandatory training.

The dementia strategy needed development for community-based services. We found evidence of poor access to services for some patients with a learning disability; simple-to-use protocols needed to be developed for this group of patients so that they could access support. The timely supply of equipment for bariatric patients needed to be addressed. Community staff worked closely with specialist staff in the mental health teams to provide appropriate services for patients with care needs that included mental health, although staff identified some communication issues with mental health services.

Referral and discharge information lacked relevant details to support appropriate transfer between services. Discharge liaison arrangements between the acute hospital and community settings required some refinement.

Learning was shared from the investigation of complaints and action plans prepared. Except for one instance, however, no recent complaints had been received from patients who used community health services.

Detailed findings

Planning and delivering services which meet people's needs

- Managers we spoke with described their approach to planning and delivering services that were responsive to the needs of patients. Staff told us that they worked with local commissioners of services, the local authority, other providers, GPs and patients to coordinate and integrate pathways of care. Services included specialist nurses and therapists for particular conditions, for example in diabetes, respiratory, tissue viability, continence, falls and stroke teams. For patients who required support for mental health or social care needs, arrangements for care and treatment were facilitated with mental health teams or social services.
- Specialist teams provided services in the community that met patient needs closer to home and were accessible, particularly in rural parts of the area. Community nursing teams addressed the needs of patients who were assessed as predominantly housebound or if their needs were identified as best being met in their own home. For patients who were more mobile and able to travel to local centres, the

service operated some community clinics. For patients who were referred for intensive occupational therapy or physiotherapy at community locations, the service was coordinated on a trust-wide basis by an advanced clinical specialist and physiotherapist.

- Managers told us that the multiple commissioners covering the large geographical area had presented some issues in planning a consistent strategic direction for the service, as commissioners had different requirements. The trust had conducted an internal review of community services during 2013 and 2014 in order to rationalise some services that had previously been planned and operated separately for the York and Scarborough areas, for example the continence service. In some areas, for example specialist diabetes nursing in Scarborough, the service was provided jointly in inpatient and community settings. Community therapy teams worked together with nursing teams; staff commented to us that these arrangements were more structured and supported joined-up care for the patient. We observed this when we accompanied community therapy staff during home visits.
- Staff also stated that the restructuring of specialist services to combine community and hospital services did not take sufficient account of the impact on clinical flows from the point of view of the patient. The single point of access operated through another trust and did not currently include therapy services, although we were informed that this was planned. For the intermediate care and fast response teams, managers in a focus group told us that the trust was piloting community response teams in Scarborough and Ryedale, as no overnight community nursing service was currently provided in those areas. The service was planned jointly with the local authority and included provision for people in care homes.
- In the Scarborough area, the community rehabilitation service was managed in conjunction with another trust, although staff said that there were capacity issues with the service. The community nursing service told us that they could be called on to provide urgent support. There was also an outreach service. Community nurses provided evening cover from 5pm to 10pm; this had previously been provided by a separate twilight service. The community nursing team did not provide overnight cover (10pm to 8.30am) or weekend cover. Overnight cover in the Scarborough area was arranged through hospice at home, although staff told us that there had been some concerns recently about aspects of this service.

Equality and diversity

- The trust's staff survey showed that 41% of staff working in community services and 48% of staff in therapy services had received training in equality and diversity in the previous 12 months. Staff we spoke with had received mandatory training in equality and diversity. A guide for staff on the use of interpreter services was available and was included in mandatory training.
- The trust had prepared an annual report for equality, diversity and human rights in September 2014. This confirmed actions taken by the trust to provide accessible patient information and access to the interpreting and translation services. The trust executive included a lead for equality and diversity.
- Some brochures and leaflets in community services were available in different languages, Braille, audio, large print and electronic versions.
- We found examples of communication with hard-to-reach groups in the Scarborough area that had been developed by community therapy services in response to the needs of the local community, including homeless patients and patients who used substances. Staff were sensitive to the challenges that this presented to community services, and were empathetic in their approach to patients.

Meeting the needs of people in vulnerable circumstances

- The trust board had received an update on the development of a dementia strategy in December 2014. An action plan had been prepared to take forward the strategy in 2015, although not all community staff we spoke with were aware of this. Staff felt that the strategy needed development for community-based services. Community nursing staff we spoke with had attended dementia awareness training, which was mandatory for some, but not all, community-based staff. Staff who had attended the dementia awareness training told us that it helped them in caring for this group of patients. The trust was to develop the use of volunteers to support patients living with dementia and was considering the appointment of a dementia friend at board level.

Good

Are services responsive to people's needs?

- Staff we spoke with indicated that a significant proportion of patients who used community services experienced some level of dementia. When we observed community nursing staff during a home visit, we saw that the patient was treated with respect, compassion and empathy. However, community nursing staff in a focus group felt that ongoing support arrangements were poor for both staff and relatives involved in caring for patients living with dementia. Community nursing staff we spoke with felt that a more proactive approach was needed to support this group of patients, including care pathways that facilitated an earlier diagnosis of dementia.
- We accompanied staff during a visit to a patient with dementia, and observed that appropriate support was given. The patient and their relative expressed their gratitude for the way they were supported by the community nursing team.
- We found evidence of poor access to services for patients with a learning disability. Information we reviewed from the National Patient Safety Agency showed that five incidents had been reported since October 2014 involving people with a learning disability using community teams; four of these were rated severe.
- Staff could refer patients with more severe needs to a learning disability liaison service and learning disability specialist nurses were available to provide support. The lead carer for a patient with a learning disability was supported to accompany the patient during visits to community services. Specialist nursing staff commented that support arrangements required the development of simple-to-use protocols.
- In a focus group, people with a learning disability and their carers spoke positively about the regular support they received from the community learning disability team. However, people also told us about issues they experienced with communication, which included staff failing to use their passport. People with a learning disability had very little accessible, easy-to-read information to help them consent to treatment.
- Community-based staff, including community matrons, worked closely with specialist staff in the mental health teams to provide appropriate services for patients with care needs including mental health. Community and specialist nursing staff commented positively about liaison with GPs and mental health services for patients with mental health needs. However, community nursing staff in a focus group felt that there were communication issues with mental health services, particularly in assessing the functional needs of patients, for example their mobility. In some locations we visited, we found that community nursing staff attended monthly primary care meetings with community psychiatric nurses; this helped provide joint support for this group of patients.
- We observed a visit to a bariatric patient by two community nursing staff, and appropriate support was provided for the patient's needs. However, we received information about the poor experience of some bariatric patients when they were admitted to hospital from community settings without the service being aware of their needs. We found evidence of problems with the timely supply of equipment for bariatric patients.
- Patient information leaflets were available for patients with new regimes of care to support their understanding and involvement. For example, there was information for new patients, information about patient safety and about pressure area care, and a guide to the home oxygen service.
- Patient information leaflets were available to promote patients' self-care. For example, the "Pressure ulcers prevention and treatment" leaflet included a section on self-care.

Access to the right care at the right time

- Community health services used a single point of access to help ensure that patients got the right care at the right time and, where possible, avoided being admitted to hospital. Commissioners supported the introduction of a single point of access as a pilot initially. An evaluation report for the single point of access prepared in 2014 showed that 97% of calls were answered with 60 seconds between April and December 2014. Also, 91% of healthcare professionals and 92% of patients were satisfied with the service. A refinement of the prioritisation criteria was identified as a key development need.
- Quality indicators for community services showed that patients were assessed promptly for care and treatment, and that this was consistently within the expectations of patients and commissioners. The trust informed us that the community national minimum dataset, which included referral to treatment times (RTT) for community services, was not to be mandated until mid-2015. This meant that at the time of our

inspection RTT times for community based services were not part of the trust's reporting on its 18 weeks targets. We reviewed information as to the number of patients referred monthly to community physiotherapy and occupational therapy services which showed the numbers of medium and low priority patients waiting for access to the service, and the length of wait in weeks. For medium priority patients, the maximum wait was four weeks, and for low priority, 11 weeks, which occurred only in July 2014 and had since reduced substantially. This was within the RTT target time of 18 weeks.

- Monitoring information showed that minimal waits for services were maintained. This was confirmed when we spoke with staff at most community locations we visited. At one location, where 10 patients had recently been waiting for more than four weeks, we found that this had been targeted so that referral-to-treatment times for urgent patients were reduced to five working days.
- We found that patients could access community health services promptly in the areas we visited. For three of the locations we visited, we asked community nursing staff about the waiting time experienced by patients who were discharged home from hospital and had been referred to district nursing services. Staff informed us that patients were usually seen the same day within a two to four hour timeframe, although the trust were unable to provide data to confirm this.
- Nursing staff expressed concerns about the staff resources available to support the rapid response service. In some areas, for example Filey, we were informed that the rapid response team had been discontinued; this presented some issues for community nursing staff in making timely assessments of patients to avoid hospital admission.
- When we accompanied community therapy staff during home visits, we found that patients were happy with their waiting times for assessment; two patients we visited who were assessed as moderate priority had been seen within two weeks of referral. Community nursing staff reported that some delays were experienced in the Filey area in arranging specialist nursing assessments. In general, however, services responded quickly and waiting times were short.

Referral, transfer, discharge and transition

- Community therapy teams provided support for all patient groups. During 2014, the service ran working groups to develop referral criteria and information required to support discharge. The referral process had been changed as a result and a revised triage and assessment protocol introduced. Standard operating procedures were in place for medications for patients discharged from hospital. In the Selby area we found that a clinical response team had recently been introduced to reduce the need for hospital admission, although this was still to be audited. The service was a national pilot site for the development of community hubs to support the delivery of care nearer to home. Two community hubs, based at Malton and Selby, had been established to support seven-day assessment for residents of care homes; this enabled early intervention and reduced the need for crisis intervention.
- Community and specialist nursing staff in a focus group told us that the introduction of the two community hubs was seen as a positive approach that was expected to facilitate early discharge and assist in preventing admissions to hospital. However, community nursing staff told us that they had experienced delays when referrals were submitted to the hub due to capacity issues, which discouraged further referrals. Community therapy staff told us that when therapy services were linked to the hubs (this was not currently the case), this would support a more integrated model of care. We reviewed update reports prepared in February and March 2015 for the hub locations; these identified progress and set out plans for further development, including to resolve these implementation issues.
- We found evidence that patients' referral and discharge information often lacked relevant details to support appropriate transfer between services. Community nursing staff at some locations told us that planned discharges from hospital lacked key information on, for example, specialised equipment needs, such as beds, and pressure care. They also told us that, although new procedures were being put in place to address these issues, this involved extra duties for community nursing staff: for example, they had to check equipment in the patient's home. Patients were frequently discharged without the supplies they needed. Therapy services told us that they experienced significant difficulties in arranging equipment for patients in some areas, but less

so in others: it depended on the local authority area where the patient lived. We were not able to ascertain to what extent this could have affected the timing of patient discharges.

- At one location community matrons told us that they followed patients into hospital to check on their needs when leaving hospital and that they provided their contact details to the hospital service. However, patients were often discharged without their knowledge. At another location, which had no community matrons, community nurses explained that there was often no information about whether newly discharged patients were housebound or being visited by practice nurses. At a further location we visited, medical staff identified complications in arranging social services support as the main obstacle to an efficient discharge. At another location we found evidence that discharges from hospital on Fridays presented particular difficulties in the care of patients with complex needs.
- Senior staff in a focus group told us that patients were followed up by the discharging service after 24 hours to review their needs. At one location, a discharge tracker audit was used to follow up 48 hours after the patient's discharge; this showed that difficulties were encountered for just 10% of discharged patients and confirmed that issues related to equipment, medication and liaison with community district nurses or social services. Although district nursing staff were invited to attend weekly discharge planning meetings, for some areas this was impractical because of their geographical remoteness. These meetings were attended by the discharge liaison team. Staff we spoke with in some primary care locations told us that the discharge planning meeting had improved care for patients, particularly in arranging their medication. GP practices were being notified of each patient admitted and discharged from hospital. A care coordinator reviewed patients daily to identify those at risk of readmission. The hub was contacted daily with details of patients admitted in the previous 24 hours; this supported the responsiveness of the service.
- Some specialist nursing staff, for example in respiratory services, told us that most of their referrals came from GPs and community nurses, rather than directly from hospital discharges, although the number of the latter had recently increased. Specialist nurses told us that an early supported discharge programme was operated by hospital-based services, although communication with acute services staff needed to improve to facilitate this. Specialist therapy staff frequently received referrals only after the early supported discharge had failed. The community therapy service had introduced a therapy handover for patients transferred between services; we were informed that this still needed to be embedded and learning shared across the trust.

Complaints handling and learning from feedback

- The trust had a concerns and complaints policy and procedure in place. This included all community-based services, although this was not specifically stated in the policy. The trust had appointed an executive lead for complaints. The trust submitted information about recent complaints for the York and Scarborough areas, but complaints relating to community-based services were not identified separately. Except for one instance, staff in community locations we visited told us that no recent complaints had been received from patients who used community health services. The one complaint received in the previous 12 months had been resolved locally.
- Information for patients on how to make a complaint was being reviewed at the time of our inspection. A separate Patient Advice and Liaison Service (PALS) leaflet was available for patients and information about complaints was available on the trust's website. A "Your experiences matter" leaflet included information about PALS and formal complaints and was available in different languages, Braille, audio, large print and electronic versions.
- Quarterly and annual patient experience reports on complaints were submitted to the trust board. An executive meeting to review complaints received was held weekly. A patient experience steering group reviewed complaints and compliments received to identify themes. Matrons and some other senior staff had received training in complaint handling, and we were informed that this information was cascaded to other groups of staff.
- Learning from the investigation of complaints was disseminated where improvements had been identified. The outcome of the investigation was shared with the patient and an action plan was prepared that senior staff shared with their teams.

Good

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

Recent changes to the structure of community services were viewed positively by staff. Senior community nursing staff were supported by senior nurse management. Senior staff had recently contributed to the development of nursing priorities for the service. Community therapy services, including occupational therapy and physiotherapy, had developed a vision statement. For community nursing services, we found that no specific vision or strategy had been developed. In some community locations, staff identified with the trust's mission statement and followed its values.

A risk management policy was in place for the trust and included community health services. A central risk register for community services and locality risk registers had recently been developed. We identified some concerns regarding the escalation of risk for community services, although we were assured that the governance of community risks was under review. The corporate risk committee met quarterly and included community services.

The governance structure of the trust included an operational community services group. The management arrangements for community services were being reviewed. An assistant director of nursing had recently commenced in post with specific responsibility for community services. A monthly performance report was prepared for community nursing services for each area and monthly activity was monitored for community therapy services. Senior staff met monthly to review clinical and managerial issues, to develop action plans resulting from audits, and to share learning. Learning was also shared at regular team meetings with nursing staff.

Some staff we spoke with had met the chief executive and knew their name, although they felt they were isolated from staff at executive level. Staff felt that they could approach the chief executive through "Open door" events. Community matrons told us that they felt there was good leadership of their service. We found a mainly positive culture in the community locations we visited. However, several community teams told us that there was a hospital-focused, acute culture in the organisation with York seen as the centre. Clinical leadership required development and staff expected some shortcomings in clinical and managerial leadership to be addressed by the recently appointed director for community services.

The Friends and Family Test had been used in community services only since February 2015. At the time of our inspection, no feedback had been received. Some other mechanisms for engaging with patients and the public were used. There were mixed results from the NHS Staff Survey. We saw several examples of engagement activities with staff.

We found some examples of new and emerging innovative practice. For example, the service was a national pilot site for the development of community hubs to support the delivery of care nearer to home.

Detailed findings

Service vision and strategy

- The trust had developed a trust mission statement setting out its values, vision and strategy. The mission statement included brief information about shared commitment, caring with pride, values, drivers and motivators. Senior staff had recently contributed to the development of nursing priorities for the service.
- Community therapy services, including occupational therapy and physiotherapy, had developed a vision statement following a visioning event held in 2013 and a follow-up event. The service worked to promote independence and to maximise the health and function of patients at home and in the community hospitals as part of an integrated approach to rehabilitation. The aims and objectives for the community therapy service were to contribute to the vision and strategic objectives of reducing health inequalities and improving the health of all people in the Vale of York, Scarborough, Ryedale and Whitby communities. We found that senior managers of the service and most therapy services staff

identified with this vision and strategy and felt it was clear. However, staff in one specialist service we visited told us that they did not feel connected to the trust's strategic direction and did not feel involved.

- For community nursing services, we found no specific vision or strategy had been developed. However, in some community locations staff told us that they identified with the trust's mission statement and agreed and followed the stated values. We saw that the trust's mission statement was displayed on staff noticeboards in locations we visited. Nursing staff in some other community locations were unaware of this and felt that the service lacked an identified vision and strategic direction. We received information in which staff expressed concerns that their roles and responsibilities were unclear. In one location, staff told us that they felt community nurses' views had no effect on the trust's strategy. Staff in a focus group told us that some nursing staff felt they had an insight into the trust values, although they were felt to be "Top down". The focus group confirmed the view that there was no identified nursing strategy for community services.

Governance, risk management and quality measurement

- A risk management policy was in place for the trust and included community health services. A central risk register for community services and locality risk registers had recently been developed. The community therapy service had developed a local risk register and had completed security risk assessments for two community locations where the service was based. It had also developed an action plan to mitigate risks. We identified some concerns regarding the escalation of risk for community services, although we were assured that the governance of community risks was under review. The corporate risk committee met quarterly and we saw from the minutes that community services were included in the committee's remit. Community nursing staff we spoke with confirmed that they were aware of the corporate risk register, but told us they had not needed to access it. We reviewed the risk register maintained by some senior community staff and saw that key risks were included, for example staff vacancies and lone working. However, this was not linked robustly to the directorate or corporate risk register.
- The governance structure of the trust included an operational community services group. An assistant director of nursing had recently commenced in post with specific responsibility for community services. A professional nurse leaders' forum was held for the community nursing service and was chaired by the assistant director of nursing; we saw from the records that the meeting addressed root cause analysis, lessons learned and action planning. The forum had recently focused on pressure ulcers, falls and medication errors. We were informed that learning from the forum was cascaded to team leaders and to community teams. Senior specialist community staff felt that line management and accountability were clear and they knew where to go if they had an issue. However, some community nursing and specialist staff told us that they were unclear about where they fitted in the governance structure.
- Community and specialist nursing staff in a focus group told us that the management of community services was not well structured, although they were aware that management arrangements were being reviewed. Some staff told us that they had had up to six different line managers in the last two to three years, which they felt adversely affected the development of the service.
- A monthly performance report was prepared for each area of community nursing services. The reports presented a summary of community adult nursing activity so that trends could be identified and monitored. A patient safety dashboard was prepared for each community location; this included incident reporting, pressure ulcer incidence, falls incidence, deaths and mortality reviews, NHS Safety Thermometer data and a patient safety dashboard summary.
- Monthly activity statistics were prepared for community occupational therapy and physiotherapy in the York and Scarborough areas. Information included new referrals, new patient contacts, follow-up contacts, telephone clinical contacts, discharges, number of patients waiting, and the maximum length of wait. The community dashboard information was reviewed by the quality and safety committee, which met monthly. We reviewed the minutes of these meetings and saw that they included executive representation and covered a review of activity by locality. We found that some senior staff had addressed shortfalls in governance systems for their area of responsibility by developing local governance arrangements, for example to review sickness absence, mandatory training and staff appraisals.

Good

Are services well-led?

- Regular team meetings were held for each community-based service, including community nursing teams in each area, specialist nursing and community therapy services. For community therapy services, teams held a monthly meeting chaired by the principal clinical manager, while team managers held team meetings every six weeks. Community staff we spoke with confirmed that senior nursing staff met monthly to review clinical and managerial issues and that community matrons and case managers were also involved in meetings to develop action plans from audits and to share learning. Learning was also shared at regular team meetings with all nursing staff. Staff were required to attend and the meetings were minuted. We reviewed the records of these meetings. For community therapies, for example, we found that the senior manager for therapy services held monthly meetings with team managers to review pressure areas and targets. Staff were briefed with feedback from executive meetings, changes to guidelines, and the outcomes of working groups, as well as discussing health and safety and statutory and mandatory training. Team leaders prepared action plans to address issues arising from these meetings.
- Specialist nursing staff expressed concerns that some community staff did not attend meetings because they felt they were mainly focused on acute settings, and they were not managed as one integrated team.
- We observed a handover meeting between community nursing staff where there was open discussion and in which staff demonstrated a clear knowledge of patients' medical conditions and their care and treatment. Handover meetings were held daily, but staff told us that it was difficult to get the whole team together. Handovers between day and night staff mainly took place remotely.

Leadership of this service

- Some staff we spoke with had met the chief executive and knew their name, although they felt that they were isolated from staff at executive level. Staff felt that they could approach the chief executive through "Open door" events although they were not aware of any executive visits to their locality. Staff at one location told us that senior managers and the trust board were not visible, and at another location staff said the community nursing service seemed to lack a leadership profile. However, some staff told us that they appreciated attending the workshop for community staff that had recently been delivered by the chief nurse to explain changes in the structure of community services. This had conveyed a clear message from the top of the organisation.
- Communication with lead managers was described as good by several members of staff. Community nursing staff felt that they had good support from senior nursing staff and any issues could be aired openly with their management team. The manager of a specialist service said they felt that pressures in community services were listened to and responded to by senior managers. However, a lack of communication from the centre was also mentioned as a significant issue by several staff.
- Senior community nursing staff told us that they were supported by senior nurse management within the trust. They felt supported in their role and development. Community nursing staff in two primary locations we visited told us that they felt well supported by their team leader and immediate line manager. Team leaders reported to a locality manager, and the locality manager to the executive. However, in one location nursing staff told us that the recent changes in management processes had left them with increased workloads and management processes were not clear.
- Community matrons told us that they felt there was good leadership of their service. In community therapy services, staff said that they had become more positive about the leadership changes and felt there was clear management accountability and support available. The establishment of therapy teams had given a clearer identity for therapists and enabled leadership and management of the service to be delivered more effectively. A senior manager described their team as willing, motivated and flexible.
- At one location, community nursing staff told us that there was a lack of understanding of the role of community nurses by senior staff, although there had been some improvement over the last 12 months. Staff were aware that the assistant director of nursing with specific responsibility for community services had recently begun working in the service. At another location, the manager for the community therapy service described how they had used an innovative leadership approach to help overcome the effects of previous poor management practice. They had listened to staff and had introduced daily delegation of duties.

Good

Are services well-led?

- Specialist nursing staff at one location told us that they felt they were not managed as one integrated team, although management support was available and staff were in regular contact with the locality manager for the service. At another location, a specialist nurse told us they felt disconnected from the centre, and they felt there was a lack of support, even when issues were escalated.
- We asked staff about the clinical leadership they received. Clinical leadership was often arranged informally through medical consultant staff. Specialist acute services also supported specialist staff working in community services. Community nursing staff in a focus group told us how changes in their management and clinical responsibilities had been affected by changes in the leadership of the service. This had adversely affected the clinical leadership of community health services. At one location, staff told us that they felt there was poor clinical and managerial leadership. Some nursing staff felt that they had received little support during long periods covering for sickness absences and that there had been a lack of clinical leadership in addressing some governance issues. Staff expected shortcomings in clinical and managerial leadership to be addressed by the new director for community services.

Culture within this service

- We found a mainly positive culture in the community locations we visited. Comments we heard typically stated that staff worked in a close team in which morale was good and staff felt valued. Staff were happy to help each other, and there was an open and honest approach to providing support. Staff contacted their manager or each other with any concerns. Some staff told us that they felt they thrived under pressure and they did not see the job as a chore, although they also said they felt the service survived on the good will of staff. Other staff told us that they loved coming to work and it was probably the best team they had worked in. Staff clearly enjoyed their role as community nurses. Staff in community therapy services told us that there was a clear culture and therapy staff felt liberated by the revised structure of the trust. Staff who had recently joined the service told us that it felt organised and friendly.
- Managers and senior staff in a focus group told us that they were willing to try a different approach where this was needed and they had a passion for the services they provided. Senior staff we spoke with said that the positive experiences reported by community nursing staff were a direct result of bringing the previously separate organisations together.
- Several community teams told us that there was a hospital-focused, acute culture in the organisation with York seen as the centre. To some extent, they were seen as the poor relations, and this was often reflected in the allocation of resources and working in isolation. Hospital-based staff needed to develop their understanding of community services. At one location, the culture within the organisation was described to us as “Ticking boxes”. Staff in another location said that they felt detached from strategic developments.
- Community and specialist nursing staff in a focus group told us that they felt it was a privilege to work with patients and the culture was changing slowly for the better, although this improvement was described as patchy. They said there was little recognition of the extra hours they worked or the commitment they gave.
- During our visit, we received information from staff at one location stating that staff morale was very low; staff felt that their expertise and skills were not recognised, they felt undervalued by the organisation, and workplace stress was increasing.

Fit and proper person requirement

- The statutory fit and proper person requirement had applied to NHS trusts from November 2014. The trust had a policy in place relating to this new requirement.

Public and staff engagement

- The Friends and Family Test had been used in community services only since February 2015. At the time of our inspection no feedback had been received by the service.
- The trust used “Knowing how we are doing” boards that provided a focus for patient experience, including use of the Friends and Family Test feedback.
- We found that there were mixed results from the NHS Staff Survey. Key findings included the following for community services and therapies: 71% of community services staff and 70% of therapies staff felt satisfied with the quality of work and patient care they were able to deliver, and 91% of community services staff and 94% of therapies staff agreed that their role made a

difference to patients. However, only 35% of community services staff and 37% of therapies staff agreed that feedback from patients was used to make informed decisions in their directorate or department.

- The trust informed us that the results of engagement with community health service patients about their experience of using services were not recorded separately. Compliments received about services were also recorded only for the trust as a whole. We reviewed the results of several service-specific patient satisfaction surveys, for example for the continence advisory service. The audit survey conducted in 2015 for the York and Selby area showed a high level of satisfaction with the service and the advice provided had improved quality of life for most patients. Each of the respondents stated that they would recommend the continence advisory service to friends and family. The community stroke team in the Scarborough area conducted patient satisfaction audits during 2014/15, although we did not review the results of these.
- In three primary care locations we visited where community service staff were based, we found that "Your experience matters" audits were conducted to capture the views of patients, although we did not review the results of these. In each location we saw evidence that patients had commented positively on the service; a selection of these comments were displayed.
- The service provided several examples of its engagement activities with staff. For example, to support the implementation of the community hubs in Malton and Selby, staff workshops were held in September 2014 to engage with staff about developments that affected them.
- A workshop to engage with staff about regional and local priorities for the nursing service, including aspects of community nursing and patient and public involvement, had been held in January 2015. An evaluation of feedback showed that most staff who attended rated the workshop as excellent or good. Community and specialist nursing staff in a focus group confirmed their involvement in this process and felt that staff were listened to and actions from the workshop had been taken to the board.
- Community therapy services had held a staff engagement workshop in March 2014 so that community therapy staff from each locality could be involved in developing changes to community teams. The community therapy service had prepared an end-of-year review in December 2014 which included the results of staff involvement in developing outcome measures for the service. This followed a previous visioning day that was held in 2013 to involve staff in supporting the restructure of community and therapy services.
- We found that a therapy patient satisfaction survey was used to evaluate the service and 94% of respondents rated the service as excellent or good. Respondents said that they would recommend the service to friends and family.

Innovation, improvement and sustainability

- Community health services were included in a trust scheme to reward staff innovation through a star recognition award given by the chief executive. We saw that information about the award scheme was included in the staff newsletter and displayed on staff noticeboards. At one location we visited, in Selby, we saw evidence that the team had been nominated for a star award for its local performance as a result of a letter sent by a patient.
- In therapy services, commissioners had supported a project to develop a triage process, prioritisation criteria and a referral system linked to outcome measures for assessing the effectiveness of the service for patients.
- The service was a national pilot site for the development of community hubs to support the delivery of care nearer to home. Two community hubs, based at Malton and Selby, had been established to support seven-day assessment for residents of care homes; this enabled early intervention and reduced the need for crisis intervention.
- At one community location, in Easingwold, we saw that nursing staff had developed an indexed guide and directory of services in the area for the public, patients and staff to use.
- Staff in community services were involved in implementing service redesign to support cost improvement plans. We saw that the trust's cost improvement plans for 2014/15 included a number of schemes involving community services. However, senior staff in some locations we visited were unaware of these developments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing. How the regulation was not being met: The provider did not have suitable arrangements in place in order to ensure that persons employed for the regulated activity are appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users safely and to an appropriate standard including by receiving appropriate training, professional development, supervision and appraisal. This was in breach of Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure there are suitable arrangements in place for staff to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing. How the regulation was not being met: The provider did not have suitable arrangements in place in order to safeguard service users as persons employed for the regulated activity were not appropriately supported when working alone in the community.

This section is primarily information for the provider

Requirement notices

This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must review arrangements to support staff working alone in the community to ensure their safety.