Calderdale and Huddersfield NHS Foundation Trust

RWY

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)
RWY95	St John's Health Centre, Lightowler Road, Gibbet Street, Halifax. HX1 5NB		
RWY07	Todmorden Health centre, Lower George Street, Todmorden. OL14 5RN		
RWYX1	Broad Street Plaza, 1 North Parade, Halifax. HX1 1YQ		
RWY02	Calderdale Royal Hospital, Salterhebble, Halifax. HX3 0PW		<

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated this service as good because:

- We found this was a service where the patient was put first and holistic care was delivered.
- The service had a system in place to report incidents and staff were able to use this.
- Staff were able to give examples of where they had learned from incidents and how improvements had been implemented.
- Staff sickness levels were lower than the trust target and staff morale was high.
- Staff delivered evidence based care and treatment and followed appropriate national guidance.
- We observed kind and compassionate care being delivered by knowledgeable staff and patients told us they were happy with the service they received.
- There were fully integrated multidisciplinary teams that worked effectively in a variety of settings. A seamless service was provided with a combination of health and social care input.
- There was a range of services offered and patients did not have to wait long for care and treatment.
- There were a low number of complaints received by the service.
- There was a well-managed risk register with action plans and control measures in place.
- Despite a recent significant change in the trust structure and management arrangements staff told us they felt well supported and that managers were approachable.

However:

- Mandatory training levels were below the trust target.
- We found there had been some staff shortages but the service had managed this well.
- Some documentation required updating and standardising across the service.
- There was a lack of comprehensive performance data within the community services. This was impacting on their ability to properly measure effectiveness and responsiveness of the services within the division.
- Complaint responses and lessons learned were not always shared with staff in an effective or meaningful way but plans were in place to improve this.
- Community equipment was not well managed therefore staff were not aware of what equipment was available or if it was safe to use.
- Staff felt that senior managers in the trust did not fully understand the pressures on staff who worked in the community.

Summary of findings

Background to the service

Calderdale and Huddersfield NHS Foundation Trust (CHFT) serves a population of 450,000 and provides community services to adults in Calderdale within the Community Services Clinical Division. Calderdale has a population of 205,300 and covers an area of 140 square miles (2012 ONS (Office for National Statistics) Mid-Year Estimates). The latest ONS population projections estimate that the population of Calderdale will reach 221,000 by 2033. Community Services in Huddersfield and surrounding areas are provided by a social enterprise organisation called Locala.

The trust has four clinical divisions following a re-structuring process in 2015 and this had resulted in the formation of a new separate community division. There are a number of adult community services arranged and managed in the community services division. These are:

- District nursing including an out of hours nursing service.
- Rehabilitation services – including:-
- Intermediate care team
- Crisis intervention team
- Falls prevention team
- Support and independence team (SIT)
- Early supported discharge (stroke) team
- Elective orthopaedic rehabilitation and Muscular Skeletal Disorders team
- Podiatry & Orthotics
- Virtual ward
- Speech and Language Therapy
- Dietetics
- Heart Failure Specialist Nurse including Cardiac Rehabilitation
- Lymphedema Service
- Community Matrons including Specialist Parkinson's Disease nurse
- Continence Advisory Service
- Respiratory Services – pulmonary rehabilitation, specialist TB nurse, early supported discharge.
- Crisis Intervention team
- Quest for Quality team

The locality of Calderdale is divided into five areas, Lower Valley, Upper Valley, North Halifax, Central Halifax and South Halifax.

We inspected the following services:-

- District Nursing including out of hours service
- Community Matrons
- Podiatry and Orthotics
- Support and Independence Team (SIT)
- Crisis Intervention team
- Intermediate Care team
- Quest for Quality team
- Virtual Ward team
- Continence advisory service

In total the trust recorded 224,000 adult community patient contacts last year. A number of community services had been affected by a transfer of services to another provider last year in the Huddersfield area.

As part of the inspection we spoke with 14 patients and two relatives, 32 staff including nurses, therapists, senior managers, team leaders, administration and clerical staff. We looked at the care records of 20 patients and accompanied staff as they performed their duties in a variety of settings. We also visited staff bases in each of the five areas across the locality. We looked at comment cards left by patients and their families about the services they had used just before and during our inspection.

Prior to the inspection we reviewed performance information from and about the trust.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Care Quality Commission

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, community nurses, therapists and a nurse director.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team inspected the following eight core services at Huddersfield Royal Infirmary and Calderdale Royal hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostics

The community health services were also inspected for the following core services:

- Community adult services
- Community end of life
- Community children's services

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held stalls at Calderdale Royal Hospital and Huddersfield Royal Infirmary on 29 February and 1 March 2016 and provided comment cards and boxes at a number of locations across the organisation. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection.

Focus groups were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas, outpatient services, community clinics, and in patients' homes when visiting with District nursing teams. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

Summary of findings

What people who use the provider say

People we spoke with and who used the service said that the service was good. They said that staff were kind and caring and they always came when they said they would.

Analysis of comment cards received from people, who used the community services in Calderdale, showed that most people were very happy with the service provided and there were positive comments about staff and the service they had received. The only negative comments were related to appointment making processes in some services particularly in relation to telephone messages being left.

Good practice

Staff working across the service have had significant challenges during the winter months in providing a service to patients as a result of serious river flooding. Patient's needs have continued to be met over this period despite subsequent road closures which were still in place at the time of our inspection have

Multidisciplinary and multiagency working was completely integrated in some teams with staff having a good understanding of each other roles particularly in the SIT. This led to a seamless service for patients and there was a collective responsibility to meet patients' needs in the community.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Importantly, the trust must:

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure that interpreting services are used appropriately and written information is available in other languages across all its community services.

In addition the trust should:

- The trust should ensure that the equipment inventory is updated in community adult services and that all equipment in use is properly maintained and checked.
- The trust should ensure there are systems to measure effectiveness and responsiveness of the services within community adult services.

Calderdale and Huddersfield NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Overall we rated safe as good because:

- Systems were in place to report incidents. Staff told us they knew how to report incidents and most staff received feedback from these.
- A robust improvement plan was in place to reduce the number of patients developing pressure ulcers.
- Most staff were up to date with mandatory training.
- Patient records were up to date and thorough.
- Equipment and premises were clean and medicines were managed well.
- Staffing levels were satisfactory in most teams and sickness levels were low.
- Business continuity plans were robust and had been tested in recent months.

However:

- There was a lack of control and assurance regarding equipment and medical devices. This meant that staff were not aware of what equipment was available or if it was safe to use.
- A recognised early warning assessment tool was not in use to assist in the detection of a deteriorating patient.
- Infection prevention and control measures were in place but there was not a robust system for monitoring and checking compliance.
- Moving and handling assessments were not routinely undertaken.

Detailed findings

Safety performance

- The district nursing service contributed to the monthly quality indicators data collection for the nursing dashboard for community services. However this dashboard was thought to be complex and difficult for some staff to understand.
- Senior managers had recognised that a Patient Safety Thermometer specifically for the community was required and plans were in place to develop this. The NHS safety thermometer is a nationally recognised improvement tool for monitoring, measuring and

analysing patient harms and the percentage of harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.

- The existing reporting mechanism for safety thermometer information was not able to present data at team level. Managers were aware of this and were working to develop a robust mechanism in order to target any improvement work that may be required.
- Senior managers told us that patient safety walkabouts were planned. We saw a draft programme for this but it was not in operation at the time of our inspection.
- Information provided by the trust showed 96.51% harm free care in October 2015 and 95.63% harm free care in November 2015. The year to date total for the service was 94.7% harm free care which was just below the trust target of 95%.

Incident reporting, learning and improvement

- All safety alerts were sent to all staff with a trust e-mail address. Staff told us they were aware of these.
- The trust used an electronic incident reporting system and all staff we spoke with were familiar with this and were able to report incidents.
- The trust used a red, orange, yellow and green rating for the incidents with red being the greatest harm and green being the least or no harm.
- In the six month period from 1 June 2015 to 30 November 2015 there were 206 incidents reported on the electronic system from the community adults' service. Of these, 35 had been rated as red. These were all pressure ulcers of category 3 or category 4. Two incidents were rated as orange. These related to a medication review which resulted in a patient admission and a poor discharge from the acute hospital. 176 were rated as yellow (6 of these were no harm incidents) and only one incident had been rated as green. This incident was related to a violent incident that had occurred in a patient's home.
- The managers in the community division had undertaken a thematic review on root cause analyses and investigation from reported pressure ulcers in October 2015. It was found that a majority of those reported were not acquired in the community. A new pressure ulcer pathway had been developed as a result. Staff had been trained regarding the use of the incident reporting process to ensure that classification of pressure ulcers was accurate.
- We saw on minutes from January 2016 that pressure ulcers were discussed at district nurse team leaders' meetings.
- Managers held a quality improvement workshop in November 2015 as the previous target set for reducing pressure ulcers by 10% had not been reached. The workshop identified a number of issues and an action plan was in place.
- Therapy staff and staff in care homes were to have training on pressure ulcers and a leaflet to advice patients and carers had been developed.
- A trial of daily safety huddles where staff from different disciplines would come together had been started at Brighouse and Northowram Health Centres. This was to ensure patients who were a high risk of developing pressure damage or had an existing pressure ulcer were discussed. This was a new system and was not working effectively at the time of our inspection due to it being a newly introduced idea. Managers were aware of this and were introducing it gradually across the teams.
- The trust had reported three serious incidents relating to community adults services to the Strategic Executive Information System (STEIS) between September 2014 and December 2015. Two related to pressure ulcers in September 2014 and the third was a human resources (HR) matter that occurred in January 2015. This had subsequently been de-logged from STEIS and the trust told us they were still dealing with this incident through HR processes.
- The trust had reported 472 incidents to the National Reporting and Learning System (NRLS) between January 2015 and February 2016. Sixty three of these incidents were reported as causing severe harm (permanent harm) and had occurred in patients' homes. When we asked about the serious harm cases this was attributed to category three and four degree of skin tissue damage (pressure ulcers).
- Some staff told us they had received feedback from incidents they had reported and gave examples. However some staff told us they had not received feedback. They said that some meetings where incidents would be discussed had been cancelled due to staff shortages.

Good

Are services safe?

- Some staff were able to tell us about learning from incidents they had been involved in and were encouraged to find solutions. However sharing of this information and learning for other teams was inconsistent.
- Work was ongoing at the time of our inspection to improve the use of the incident reporting system for the community division. Senior managers were aware there needed to be a trends analysis report. This would provide a better understanding of the incidents and share lessons more effectively.
- Managers were planning to develop a staff news magazine to focus on lessons learned within the community division.

Duty of Candour

- In November 2014 the duty of candour statutory requirement was introduced and applied to all NHS Trusts. This was to ensure openness and transparency to patients if things went wrong in NHS care.
- Staff we spoke with were aware of the duty of candour requirements but some staff had not received specific training on this.
- On review of district nurses' team meeting minutes we found that a decision had been made by senior managers to change the process for sending a duty of candour letter to patients. This was in order to establish whether the pressure damage was attributed to lack of care in the community following validation at a risk management meeting. Patients were now contacted after validation at this meeting whereas previously this had happened at an earlier stage in the investigation process. Senior managers confirmed this when we spoke with them.

Safeguarding

- The trust lead for safeguarding adults and children was the director of nursing and there was a named person for the role of head of safeguarding.
- Staff were aware of the safeguarding process and knew where to refer to if required. Information provided by the trust showed there were 59 safeguarding alerts in the period April 2015 to February 2016. There had been 14 allegations of abuse against the community division in the same period. Eight of these were related to pressure damage, four were neglect, one was a failure to gain consent and one was an allegation of psychological abuse.
- The trust provided mandatory training for safeguarding at three levels. All staff that were Band 6 or above and some other designated staff in the community teams were expected to complete level 3 safeguarding adults training. Information provided by the trust showed that staff in the community were 83.2% compliant with this training in February 2016 against a trust target of 100%.
- All safeguarding incidents were reported on the electronic incident reporting system.

Medicines

- Staff who administer medicines were required to attend a training programme. There were 46 members of staff who had attended medicines management training. The services was scoping how many other staff required this training in the future.
- All staff who were prescribers of medication were required to attend updates at Huddersfield University.
- A pharmacist in the Quest for Quality Team undertook medication reviews for care home residents who were new admissions or had been in hospital recently.
- Patient Group Directives (PGDs) which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment were in place. These were used for the administration of certain medications such as influenza vaccinations. Staff who administered the medications were required to sign for those on the list of PGDs. An audit in October 2015 showed that some PGDs in the community required updating. However the one for influenza was still in date.
- The trust's medicines management action plan for 2015 – 2016 identified that a transcribing policy was needed for community nursing staff. This was not in place at the time of our inspection.
- We reviewed twenty electronic medicines records. On one patient's record we found the batch number and expiry date for vitamin B12 injections had not been recorded on every occasion. This meant that if there was a problem with the manufacture of the medication it would not be possible to identify the patient who had received it. This was not in line with the trust's medicines management policy.

Good

Are services safe?

- In a patient's home we observed a controlled drug audit taking place and saw in the records inspected this happened at every district nurse visit. However the drugs were in a cardboard box in the patient's living room which was not a secure storage facility.
- In line with the trust procedures wasted medication was disposed of into the appropriate containers.
- A local pharmacy was open until midnight so out of hours staff could access medication if required.

Environment and equipment

- Staff told us they had the equipment they required to undertake their duties.
- We saw sharps bins in use in clinics and in the community which were appropriately labelled and stored with lids closed.
- We were provided with a list of community portable equipment which consisted of 1,956 items. The list was not up to date in terms of when the items were last checked or serviced. For example 183 of the 1,956 items listed had been seen in the last 12 months. There were items listed such as a Doppler Pulse Detector that had not been checked since it was installed in May 1999. Another example was an electronic ear syringe which had not been checked since December 2005.
- Nursing staff did not know when equipment had last been calibrated as there were no records available to them.
- The trust was aware of equipment maintenance assurance problems in January 2015 and had identified there were gaps in planned preventative maintenance of equipment and medical devices. The trust's in-house medical engineering department and third party companies were identified as being responsible for the servicing and maintenance of equipment and medical devices.
- It was recognised by the trust there were instances where potentially some devices may not have been included as part of the maintenance programme and in the asset register. The trust indicated that a working group had been established in January 2015 to review the provision, management and maintenance of Medical Devices in the Community Services. However when we requested minutes from these meetings we were informed there was no working group.
- An asset register was to be compiled to ensure all equipment was accounted for and staff had been requested to contribute to this work.
- A paper presented to the trust Patient Safety group in January 2016 highlighted that medical devices management was still a significant problem in the trust. Work was continuing to address this with the community management team. This was included on the community division risk register in December 2015 and was graded as a moderate risk.
- Health and Safety training was part of the mandatory programme. In February 2106 83.4% of staff had received this training, and 81% of staff had received medical devices training.
- Equipment for use by patients in their own homes such as commodes were ordered by staff through the integrated community equipment store. There was no waiting list for equipment but delivery was not possible out of hours. This had an impact on patients' care and safety particularly over weekends and had been raised by staff at the pressure ulcer quality improvement workshop in November 2015. Senior managers were aware of this but no plans were in place to improve the service.
- An inspection of premises by senior managers had identified that some clinical areas used for clinics were not fit for purpose due to carpeted floors. This posed an infection control risk as surfaces could not be cleaned properly. As a result clinics were to be held at alternative locations and steps were in place to manage the change for staff and patients.
- We observed that micropore tape had been used on a syringe driver rather than a proper label. This could be a risk to patient safety.

Quality of records

- We reviewed 20 patient records on the electronic system and found them to be up to date and thorough with no abbreviations. It was possible to tell from most records the care the patient required and who had delivered it.
- There was some inconsistency in the paper records kept in patients' home for example some did not have a signature sheet included.
- We found written entries to be legible, dated and signed and there was only one entry that was in blue rather than black ink.
- The electronic system prompted staff to update patient records and to evaluate care plans.
- The district nurses carried out a holistic patient assessment annually.

Good

Are services safe?

- A glucometer calibration had been missed on one patient for one week only.
- Information Governance training was included in the trust's mandatory training programme. Staff were required to complete this every year. The information supplied to us showed that 87.5% of staff in the community division had completed this training up to February 2016.

Cleanliness, infection control and hygiene

- The accommodation where we observed clinics taking place were clean. Equipment was also clean and labelling was used to indicate the last time a piece of equipment was cleaned.
- Standard precautions for preventing the spread of infection were in place and staff were aware of the trust policy.
- Infection prevention and control training was mandatory for all staff in the service. Information supplied to us by the trust showed that 84.2% of staff were compliant in February 2016.
- We observed staff being bare below the elbows, using hand cleansing gel and wearing appropriate personal protective equipment such as gloves and aprons. However the community division had not been auditing this aspect of infection prevention and control practice.
- We observed an instance of a nurse not following the correct procedure for aseptic technique. This was a risk to patient safety.
- Managers had identified that improvements were required to the data input from community staff to inform the infection control dashboard. There was a plan to address this but we were not provided with the timeframe at the inspection.
- A frontline ownership (FLO) audit which was a recognised assurance framework for infection prevention and control showed that in February 2016 St John's health centre scored 84% for the environment. Broad Street Plaza and Beechwood Health Centre scored 98% and 92% respectively. St John's Health Centre did not have appropriate floor covering in some of the clinic rooms. This had been identified on the trust risk register and the clinical space at the location was to be de-commissioned from March 2016.
- At the intermediate care in-patient facility the FLO results were consistently less than 85% for the three months leading up to our inspection. It was not clear what the trust plans were to address this.
- The trust infection prevention and control team had not included community staff in the hand hygiene road show events. The trust's infection control performance dashboard did not contain any information from the community division.
- Hand hygiene audits were carried out monthly and data supplied to us showed compliance was 100% most of the time. Overall compliance with hand washing technique was 99.4%.
- It was also noted that community patients were not included in an audit by the trust's infection prevention and control team of patients with indwelling urinary catheters in 2015.
- The community services did not have specific infection prevention and control team. The team were based in the hospitals and could be contacted if required. There was an identified lead nurse for infection prevention and control in the community.
- Community teams had link nurses for infection prevention and control. It was proposed that these nurses would lead on the hand hygiene audits.
- A community acquired Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia was recorded in July 2015. This was reported as a serious incident. The trust had not supplied us with the full root cause analysis but we saw the action plan that resulted from this. There was limited evidence that learning from this incident had been cascaded to staff or if the action plan had been fulfilled. For example team meeting minutes we reviewed did not mention the MRSA policy or the further training referred to in the action plan.

Mandatory training

- The trust provided information that showed a number of topics were covered as mandatory training. Much of the training was available on-line in the form of e-learning packages.
- Staff told us they sometimes undertook e-learning and training in their own time and were able to access it from home. They also told us they received an e-mail to remind them when their training was due.
- Trust data showed that 62.8% against a target of 100% of staff had completed their mandatory training in community services. However most of the staff we spoke with told us they were mostly or completely up to

date with their mandatory training. It had been identified that there were anomalies and discrepancies on the electronic training records with some delays in the system recording when training had occurred.
- Some managers were not able to see the records of staff they were responsible for. A plan was in place to address this as some staff were not being appropriately monitored for compliance with training.

Assessing and responding to patient risk

- We did not see a recognised early warning assessment tool being used in the community to detect the early signs of a deteriorating patient.
- On review of some patients' records we found that some risk assessments had not been completed particularly for moving and handling. We were told that this was not routinely undertaken which could be a risk to patients and staff.
- Community matrons had provided training to staff in care homes on the signs of sepsis.
- Through the use of telehealth technology the Quest for Quality team identified patients in care homes whose condition was deteriorating. This instigated appropriate action from the team or the GP to provide timely care and treatment for a patient. At the time of our inspection this service covered 25 care homes in the area.
- The crisis intervention team had broad criteria for referral and aimed to see urgent cases within two hours of referral. This included patients who were discharged from the emergency departments or the medical assessment unit at the acute hospital, or from community colleagues. It was rare for the team to have referrals from wards at the hospital but if they did these patients were seen within 24 hours after discharge. Within this team in December 2014 73.5% of patients were seen within two hours and in January 2016 99% were seen within two hours. This showed an improvement in performance of 25.5%.

Staffing levels and caseload

- There had been pressure on the therapy services in the community division due to increased demand and recruitment difficulties due to local and national shortages of trained staff. A recent tender of services to another provider had resulted in some staff being transferred to that provider.
- All vacancies had been filled at the time of our inspection.
- Occupational Therapy vacancies were at 10% of the establishment in February 2016. There had been a 13.83 whole time equivalent (wte) deficit across community adult therapy services. We were told that staff had been recruited and the staffing deficit had been attributed to a number of staff on maternity leave. Risks relating to staff shortage were mitigated by the trust having developed a framework for delegating duties to different staff in the team. This meant that specific duties and tasks were delegated to less qualified members of staff however, the duties were being monitored against a competency framework.
- In order to manage waiting lists for community physiotherapy an in-depth telephone triage system and additional clinics had been set up. The waiting time at the time of our inspection was two weeks which was within the trust target time.
- Managers had also reviewed caseloads and staff had also been offered additional hours to fill staffing shortfalls. Staff were also flexible and had moved to different teams and bases if required.
- District nursing staff told us that there had been pressure on their service due to increasing workload and a shortage of staff. Information supplied by the trust showed there had been a 4% increase in the numbers of patients active on the district nursing caseload in the last 12 months. The average number over the last six months being 4,542 patients on the caseload.
- Bank nursing usage in the district nursing teams was 1.7% in March 2015 and in March 2016 there were 75 hours of bank/agency physiotherapy and 346 hours of bank/agency district nursing to cover vacancies.
- Information showing planned versus actual qualified district nurses in post demonstrated a deficit of 2.75 wte up to January 2016 and a deficit of 2.68 wte for unqualified staff for the same period.
- Recruitment processes were underway with a job fair and interviews having recently taken place. Staff told us that staffing levels had recently improved and we saw evidence of this in team meeting minutes. Staff felt that the recruitment process took too long. They gave an example of applicants for a vacancy from October 2015 being interviewed during the week of our inspection.

Good

Are services safe?

- At the time of our inspection there was no acuity or dependency tool in use. Senior managers told us there was no national acuity tool for community services. However they were participating in a benchmarking exercise with other trusts to develop this.
- Senior managers told us that they were looking at scoping the workforce requirements including skill mix and caseload review, staff experience and geography. They believed that an increase in staff in district nursing services was required to meet the demands of the population.
- Nursing staff were being recruited to a nurse bank, which would assist when there were shortages of staff.
- Staff sickness levels in the community teams were 3.7% which were lower than the trust average of 4.5%. Therapy teams' sickness rates were 2.7%. These were also below the trust target of 4%.
- Some teams were not well supported by an administrative and clerical team. For example there was no staff employed for administration in one staff base which resulted in some district nursing staff undertaking this role.

Managing anticipated risks

- Within the community division there were thirteen risks on the risk register. Some staff were able to tell us what these risks were.
- From the minutes of senior managers meetings we could see that the risks were reviewed but some actions were not progressing. For example the risk relating to management of equipment had not changed for 12 months.
- We spoke with staff who mainly worked alone in community setting about the service's lone working procedures. There were robust systems in place with a buddy system and a mechanism for using a mobile phone number to summon emergency assistance if required. Staff were aware of this procedure (called the purple folder) and there was a poster for staff to remind them.
- Staff in the out of hours district nursing team always worked in pairs.
- Risk assessments were undertaken that identified issues risks and potential risks. They were shared across health and social care services and recorded on the electronic patient record. For example known drug or alcohol abuse, a dog at the property or known violent behaviour.

Major incident awareness and training

- Staff were aware of major incident plans and where to locate these on the trust intranet.
- Some staff had 4x4 vehicles. They were adaptable and changed their scheduled visits according to where patients lived in inclement weather.
- Resilience and business continuity plans had been revised. These plans had been challenged just prior to our inspection with serious flooding in the area. This had caused a number of patients to be evacuated from their homes and significant disruption to the local road network. All patients were kept safe and staff worked very hard to ensure that patient need was prioritised. Recent snowfall had also resulted in the same response from staff.

Requires improvement

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

Overall we rated this service as requires improvement for effective because:

- Patient consent was not always documented in the records.
- Guidelines had not been reviewed or standardised although work on improving this had just commenced at the time of our inspection.
- There was inconsistency in the way staff received clinical supervision and this required standardising and strengthening.
- There was a lack of comprehensive performance data within the community services. This was impacting on their ability to properly measure effectiveness and responsiveness of the services within the division.

However

- The framework for multidisciplinary working and multiagency working was very well embedded into every day practice in all the services we inspected.
- There was evidence of participation in national and local audits and some learning from these.
- There was effective care planning and goal setting for patients with some services able to demonstrate patient outcomes.
- There was a good understanding of the Mental Capacity Act amongst most staff.
- Most staff had received an appraisal and were well trained and had opportunities to undertake further training.

Detailed findings

Evidence based care and treatment

- Information supplied to us showed that a number of audits were undertaken as part of the community division improvement plan.
- The service had contributed to a number of national audits such as:

- The National British Thoracic Society Chronic Obstructive Pulmonary Disease Pulmonary Rehabilitation Audit.
- The National Cardiac Rehabilitation Audit in 2015.
- The National Intermediate Care Audit in 2015.
- The National Diabetes Foot care Audit.
- The National Parkinson's disease Audit in 2015.
- The Sentinel Stroke National Audit Programme (SSNAP)) in 2014 and 2015.

- A National Institute for Health and Care Excellence (NICE) register containing up to 32 guidelines was in place for the community division. Managers were looking to streamline this repository and standardise the guidelines in use. We saw a plan dated January 2016 for the implementation of new and updated guidelines. We did not see evidence of this having been discussed at staff meetings at the time of our inspection.
- We saw that national guidelines were being used for the assessment and prevention of falls and for the care of patients who had had a stroke.
- District nursing teams were using a modified version of the Royal College of Nursing Leg Ulcer Management guidelines but the patient leaflet was out of date.
- Staff in the rehabilitation team were aware that the NICE guidelines for Motor Neurone Disease had just been updated.
- We also saw a number of nationally recognised assessment tools in use such as:

- Addenbrookes cognitive assessment
- Minnesota cognitive assessment
- Hospital Anxiety and Depression Scale (HADS)
- Upper limb outcome measure
- EQ-5D health outcome questionnaire

- Local audits included hand hygiene and documentation audits although the trust did not supply us with information with the results of these we did see evidence in the teams we visited of these taking place.
- The intermediate care team meeting minutes reported findings from a documentation audit related to deficiencies in recording signatures, signing the signature list and recording consent.

Requires improvement

Are services effective?

- The crisis intervention team audited records on a monthly basis. In January 2016 it was found that care plans were not consistently personalised, but there was no action plan to address this finding.
- The development of the Quest for Quality team was based on a report by the British Geriatric Society. It was designed to prevent hospital admission for people living in care homes. Data collected by the team demonstrated that it was effective and the service had been fully commissioned following the pilot.
- The Virtual Ward used a LACE tool to assess the patients referred to them. This was a strategy promoted by the Institute of Health Improvement to identify preventable readmissions by assessing length of stay, acute admission, co-morbidity and emergency department attendances.
- Nursing staff were able to prescribe dressings from the wound care formulary. Other products could be prescribed following consultation with the tissue viability nurse and completion of a justification form. Feedback was given to the tissue viability nurse in order to learn and also have additional items added to the formulary.

Pain relief

- We observed patients being assessed for pain as part of the district nursing holistic assessment.
- Pain scores also formed part of the podiatry assessment.
- During a clinic we saw a patient suffering with back pain being made comfortable before a procedure was carried out. This showed that staff were aware of the patient's problems and made adjustments to minimise discomfort.
- Following a home visit that we observed a district nurse was to liaise with the patient's GP as the patient was experiencing sleep disturbance due to pain.

Nutrition and hydration

- We observed in patient records that nutrition and hydration needs were assessed using a nationally recognised assessment tool.
- Care staff in local care homes had received training on nutrition and hydration from community matrons.
- Staff were able to refer to a dietician when required. There was a community dietetic service.
- All patients over the age of 65 years had a Malnutrition Universal Scoring Tool (MUST) completed. We reviewed 20 patient records and found this to be the case.

Technology and telemedicine

- The service was working towards an agile workforce. All members of the teams had been allocated mobile working devices in the form of laptops and compatible smart mobile telephones.
- Relevant staff had received training and understood the purpose of working in an agile way.
- Staff told us there were sometimes connectivity problems and also some patients were not happy to have the computers used in their homes. This resulted in electronic records not being kept up to date. Staff told us they would complete these when they returned to base.
- Telehealth was provided by an external company and was used to identify early symptoms and allow early intervention to prevent a potential hospital admission. This was used in care homes by the Quest for Quality team and by the virtual ward team. There were plans to extend this further into patients' homes.

Patient outcomes

- The virtual ward service monitored the number of patients on their caseload that were re-admitted as an emergency within 30 days of discharge from hospital. Up to November 2015 11.4% of patients had been re-admitted. However there had been a reduction in the number of emergency re-admissions within 30 days of discharge from 14% to 11.6% between October and November 2015. This meant the use of the virtual ward service reduced the number of emergency re-admissions amongst patients who were a high risk of doing so.
- Managers were aware there was a lack of comprehensive performance data within the community services. This was impacting on their ability to properly measure effectiveness and responsiveness of the services within the division. Plans were in place to address this and an outcome evidence based framework was being developed in order to map compliance and evidence of improvements made in the service.

Requires improvement

Are services effective?

- The Quest for Quality team consultant geriatrician was able to provide complex decision making support around advanced care planning and complex medication reviews.
- The intermediate care team recorded therapy outcome measures (TOMS) for patients in their service. These were all positive in December 2015.
- The podiatry team had just started to use outcome measures so they had no data at the time of our inspection.
- The intermediate care team also monitored the length of patient stay in the intermediate care beds. The team set objective, realistic and measureable goals for patients and there was a system in place to flag up when these goals had not been reached and the team leader would look at the reasons why. Goals and aims were discussed and agreed with patients and their families.
- The crisis intervention team did not have a method of recording patient outcomes at the time of our inspection.

Competent staff

- Most staff we spoke with had received an appraisal in the last 12 months.
- Information supplied to us by the trust shows that 92.7% of staff have received an appraisal up to the time of our inspection with the trust target being 93% at that time.
- Staff in the cardiac rehabilitation team had undertaken specialised training courses for the safe exercise of cardiac people in accordance with BACR (British Association of Cardiac Rehabilitation).
- Managers were planning to review the training needs of staff in the community division for each staff group and develop an annual training plan.
- An audit undertaken in 2015 showed that there was a lack of consistency and frequency of clinical supervision in community adult services. For example a member of staff told us that supervision was part of the team meeting and a shared process. Staff told us that one to one supervision had not been available mainly due to staff shortages. A plan was in place to review the policy and implement a framework for robust supervision arrangements. A member of staff told us they were having their first one to one supervision in the week after our inspection.
- Community matrons provided education sessions to staff in care homes, such as nutrition and hydration and signs of sepsis.
- Link nurses for tissue viability were identified in the district nursing teams.
- Additional training was available for staff, such as ear syringing courses at Huddersfield University. Staff were encouraged to attend and said they were supported to do so.
- District nurses had to complete a course before they performed Doppler studies.
- Staff told us they were aware that poor staff performance was challenged and investigated.
- The continence nurse specialist provided in-house training to staff. They also provided training to care home staff, which included catheterisation, digital rectal examination and the use of bladder scanners. They used a national competency skills framework.
- Nursing staff told us there had been support from managers regarding the forthcoming and imminent implementation of revalidation with the Nursing and Midwifery Council.
- Many of the qualified staff we spoke with were mentors for nursing and therapy students.
- A consultant geriatrician provided two sessions per week to the Quest for Quality team and care homes.

Multi-disciplinary working and coordinated care pathways

- There was very good integration and multiagency working both in individual teams and across teams.
- There was a culture and willingness amongst staff to work together for patients and to provide a seamless service. For example, patients on the virtual ward caseload were pro-actively managed in an attempt to reduce the risk of admission by working in partnership with the patient, General Practitioner (GP), social services, secondary care services and voluntary organisations to ensure the patient received the right health care at the right time in the right place.
- The implementation of the Calderdale Framework of Delegation enabled a more generic workforce to provide care and treatment to patients.
- The continence advisory service was a combined adult and children's service and the team shared their knowledge.
- The local authority social services' emergency duty team were based in the same office as the out of hours'

Requires improvement

Are services effective?

district nursing team. This was a positive situation with both agencies benefiting from the security and communication aspects of working in the same environment.
- In the crisis intervention team there were multidisciplinary meetings every day. This encouraged good communication and the update of patients' care packages in a reactive way.
- Communication between health and social care professionals was good and an embedded process within the teams.

Referral, transfer, discharge and transition

- Referrals from hospital into the district nursing services were through a single point of access.
- Out of hours nursing referrals were received directly to the district nursing team via a mobile phone.
- The Gateway to Care service was based in a local authority, social services office and triaged by a nurse. This referral access point was available Monday to Friday.
- The continence advisory service was a joint adult and children's team which facilitated a smooth transfer for patients moving from children's services to adult services.
- The information received from the acute hospital to teams in the community could be very limited and at times inaccurate which could cause delays in care delivery. Staff told us that communication was improving.
- In the crisis intervention team at the time of our inspection, there were three patients who had exceeded the 72 hour time frame for discharge. The problem had been caused due to a lack of resources in the local authority and a waiting list for the reablement team. The trust were aware of this and engaged with the local authority regularly.

Access to information

- Staff accessed patient records on mobile devices in the patient's home or at their staff base. Some staff used this equipment at their own home. There was a focus on increasing agile working with less time spent travelling to and from the staff bases. Staff were aware of these plans.
- Most GP surgeries used the same electronic patient record system but not all and there were occasional difficulties with communication with those surgeries that used a different system.
- Each service had a folder on the shared drive of the trust intranet which could be accessed by staff. Within the folders were policies and guidelines relevant to that service, as well as minutes from meetings and other important information. Most staff we spoke with were aware they could access information in this location.
- Patient information was a mix of paper records which were kept with the patient in their own home or in the care home and an electronic system. The care plans we reviewed on both systems were up to date, detailed and clear.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Most staff we spoke with were aware of the Mental Capacity Act (MCA) but understanding and knowledge of application of this was mixed. For example some members of the district nursing teams demonstrated little knowledge but staff in the intermediate care team were very confident and knowledgeable.
- We observed staff gaining verbal consent from patients for care and treatment. However an incident had been reported as a safeguarding concern in 2015, where consent had allegedly not been obtained from a patient. Team meeting minutes showed staff were reminded about obtaining and recording patients' consent, prior to treatment and care.
- There was evidence in the various teams' record's audits that documenting of consent to treatment and to sharing records was sometimes omitted.
- If patients chose not to share their records with other agencies a marker was placed on their electronic record to alert staff this was the case.
- We reviewed team meeting minutes and saw that staff from the DoLs team had been invited to speak to community staff.
- The triage nurse at the Gateway to Care access point sought the consent of patients to share records prior to referring to the relevant team.
- A complaint about community services raised concerns about lack of family involvement in making decisions and obtaining patient consent. However it was

determined from the subsequent investigation that patient capacity had been properly assessed and appropriate consent had been obtained from the patient.

- We were told there was a trust wide capacity assessment form and staff had been issued with MCA prompt cards.
- Staff working in teams that covered care home settings were able to tell us the circumstances in which a DoLS application would be required and how to do this.
- Staff told us they were able to contact a best interest's assessor for advice and we found evidence of best interest meetings taking place with input from staff in the intermediate care team.
- There was no formal training programme for consent, MCA and DoLS and some staff told us they had not received any training.

Seven Day Services

- The district nursing teams provided a 24 hour, seven day service with the support of the established out of hours nursing team.
- The crisis intervention team provided a seven day service with referrals being taken by the Gateway to Care access point during office hours from Monday to Friday. The team took referrals from district nurses outside of these hours.
- The teams within rehabilitation services provided some support to patients outside of normal office hours. They liaised closely with other services in health and social care regarding on going rehabilitation programmes for individual patients.
- The community matrons, continence advice and podiatry all provided a service Monday to Friday within normal office hours excluding Bank Holidays.

Good

Are services caring?

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

Summary

Overall we rated this service as good for caring because:

- Staff demonstrated a caring and compassionate approach to the care they delivered to patients.
- Patient were treated with kindness and respect and reassurance was offered when appropriate.
- Patients we spoke with felt involved with their care and were told us they were happy with the services provided.

However:

- A higher response rate for the Friends and Family test was required and the action plan for addressing this had seen improvements.

Detailed findings

Compassionate care

- We observed staff in the teams we inspected demonstrating a very caring approach to patients and families in different settings.
- All staff listened to patients and their carers and good explanations were given about the care and treatment offered.
- During our inspection we saw that patients were treated with kindness, compassion and with appropriate levels of humour shown. Staff had a good rapport with patients they had known for a long time.
- Staff were seen to be very reassuring towards patients, their relatives and other people.
- Patient confidentiality was respected.
- Feedback we received from patients and their families about community adults' services were positive.
- There was limited Friends and Family test information as the response rate was poor at 1.5% in August 2015. In January 2016, 87.5%% of the public who had used an adult community service would recommend it. This was below the trust target of 96.2%.
- Care plans we saw in the crisis intervention team were personalised.
- One patient in the intermediate care facility told us they were happy there and that the food was OK.

Understanding and involvement of patients and those close to them

- Patients and their families were involved in patient care if the patient wished them to be.
- We noted that one patient was not able to have a morning visit which was their preference; however an explanation was given by the staff member. The patient had refused to attend the surgery to see the practice nurse.
- Staff demonstrated their knowledge of carers' assessments and a carer told us this had been offered to them.
- Patients told us that staff always introduced themselves and we saw this is in our observations.

Emotional support

- Patients were treated with respect and dignity and we saw examples of this during our inspection.
- We observed a patient in a new setting being spoken to in a reassuring way, with the member of staff kneeling down to be at the same level and using therapeutic touch.
- On care records we reviewed we found there was consideration given to a person's spiritual needs.
- Patients who were at the end of their life were cared for by the district nursing teams with support from the palliative care team. This team had the expertise in symptom control and management of end of life care.
- There was no clinical psychologist in the stroke rehabilitation team. At the time of our inspection no funding had been secured for this position.
- Staff were aware of the local counselling service available from another provider.

Good

Are services responsive to people's needs?

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

Summary

Overall we rated this service as good for responsive because:

- There was a strong commitment demonstrated amongst staff to meet the needs of the local population in a setting that was close to home.
- Waiting times for services with an appointment system were within acceptable timeframes and were flexible to take account of patients' needs.
- There was a seamless transition between services for patients as their needs changed.
- Care planning was good and reflected the needs of patients.
- There was evidence that staff learned from incidents and complaints and changed practise as a result.

However:

- Interpreting and translation services needed to be used appropriately.
- There was a lack of information available to people who did not have English as their first language.
- Although dementia training was mandatory there was no specialist nurse in the community adult's service. This may lead to patients living with dementia not receiving appropriate support.
- Some patients told us that making appointments in some services was difficult.

Detailed findings

Planning and delivering services which meet people's needs

- The trust and the community services were to be involved with one of the 29 new care model vanguards that were proposed nationally. The vanguard, called Calderdale Health and Social Care Economy, was a collaboration of the following organisations:

- Pennine GP Alliance (representing 23 out of 26 Calderdale practices)
- Calderdale and Huddersfield Foundation Trust
- Calderdale Clinical Commissioning Group
- Calderdale Metropolitan Borough Council
- South West Yorkshire Partnership Foundation Trust
- Locala Community Partnerships (NHS)
- Voluntary Action Calderdale (representing 128 health-related 3rd sector organisations).

The purpose of the vanguard was to deliver integration across all services, delivering care outside of a hospital setting through a single point of access. The current providers would work in joint community based multi-disciplinary teams in all parts of Calderdale made up of an expanded team of community, social care, primary care, mental health and pharmacy services. This meant that patients who, for example, currently need support from a district nurse, social worker and a local pharmacist will be able to access this range of support in one place through a co-ordinated approach to ensure their needs are met.

- The Quest for Quality team were contacted by care home staff through a single point of contact. This was managed by one of the community matrons. The service included support, advice or guidance and when required, a visit from a member of staff.
- The rehabilitation services included a number of teams such as the SIT who assisted people to regain their independence after an accident, illness or injury in order to live at home after hospitalisation or prevent hospital admission.
- There was an early supported discharge service for patients who had had a stroke.
- The virtual ward were also responsible for the coordination of outpatient parental antimicrobial therapy. This service delivered intravenous antibiotics to patients at home or as a ward attender and therefore prevented unnecessary hospital admissions.
- Patients were admitted and discharged from services in a seamless way with good communication demonstrated throughout.
- Care plans we reviewed were personalised and detailed.

Equality and diversity

- Information supplied to us by the trust showed that PREVENT training, introduced nationally in 2010 as a counter terrorism effort was mandatory and the compliance rate was 82.6% against a trust target of

Good

Are services responsive to people's needs?

100%. Equality and diversity training was also mandatory for staff and the community division compliance rate was 86.8% against a trust target of 100% in February 2016.

- Staff were able to access a translation service which was provided by an external organisation who were a member of the NHS framework. There was a telephone service as well as interpreters being available to accompany staff if required. The top three languages used in 2014/2015 were Punjabi, Urdu and Polish. Staff reported that this service was less responsive than the previous provider and that they sometimes had concerns about the professionalism of the staff.
- Staff in the continence advisory service told us they would ask family members to attend appointments if there were language or communication issues identified.
- There was a lack of availability of leaflets in other languages than English. Staff told they could request leaflets to be produced in other languages as and when required. The English version of some leaflets we saw stated these could be reproduced in other languages. However some staff told us that this was not the case and gave an example of when it had not been possible.

Meeting the needs of people in vulnerable circumstances

- Community services had recently reviewed the housebound policy and this required agreement from primary care and the clinical commissioning group.
- District nurses visited patients who were housebound in their own home which included care homes. However, we found that in some instances they were visiting patients who were able to attend a health centre or surgery but chose not to.
- The crisis intervention team assisted people in their own homes with emergency care packages and therapy input for up to 72 hours to avoid a hospital admission.
- The rehabilitation teams also provided expertise in the management of long term health conditions and fatigue.
- Dementia training was part of the trust's mandatory training programme. Data showed that 82% of staff in the community division had received this training up to February 2016. There was no specialist dementia nurse in post in the service.
- Patients with a learning disability were identified on the electronic patient record with a special symbol. Staff we spoke with in different services were aware of this and liaised with the learning disability teams when needed.

Access to the right care at the right time

- Admission criteria for each of the community services meant that patients could be assessed and cared for in community settings with different levels of dependency and needs.
- Patients told us that it was sometimes difficult to contact services in order to make an appointment. They informed us that on occasions unanswered messages were left on answer machines. This was not in line with the trust's telephone answering standards.
- Some health centres did not have 5 day a week receptionist cover so an answer machine was used or a central appointment line. Some staff we spoke with said that elderly patients found the central booking line difficult to use and preferred to come to the health centre and make an appointment in person.
- The elective orthopaedic rehabilitation team facilitated discharges from the orthopaedic unit at Calderdale Royal Hospital for patients who had joint replacements.
- The local clinical commissioning group commissioned 41 beds in care homes for step up from home and step down from hospital care and therapy. Nursing and therapy input was from the intermediate care team who worked closely with the care home staff.
- The virtual ward team spent time roaming the hospital wards to assess patients already known to community services to facilitate a speedier discharge.
- Overall, the referral to treatment times were good. Data showed the community division, where there was a referral and waiting list process, all but two services had achieved a higher than 95% rate in being seen before the national 18 weeks maximum target waiting time in the period March 2015 to February 2016. The services that did not achieve this were podiatry at 85.7% and the 'drop-in' service which was 75%.

Learning from complaints and concerns

- The trust had a complaints policy and procedure. We saw there was complaints information available for people in the locations we visited.
- There were seven complaints received about the services from 1 December 2014 to 30 November 2015.

Good

Are services responsive to people's needs?

- The service that received the most complaints was podiatry. Out of the seven complaints four were upheld, two were partially upheld and one investigation was ongoing. The identified themes or trends with these complaints had been identified by managers as sepsis management and communication.
- The information provided by the trust showed up to November 2015, 12.5% of complaints received by the service had been responded to and closed within the target timeframe. The trust target was for 100% of complaints to be dealt with within this time. However when we asked managers about this we were told this was due to a complainant choosing to have a significant time to consider the responses made by the service at different stages meaning that the process was delayed.
- Staff in the podiatry service were able to inform us that they had received feedback from a complaint and had changed practice as a result. This related to appointment times that had required changing and allowed time for explanations.
- Staff in the district nursing teams told us if a concern was raised they would initially attempt to resolve it at a local level.
- There was no record of informal complaints or concerns being logged but senior managers were planning to improve this. There was also no log of compliments that were received by some teams. This meant they would not be able to monitor trends within the service and change practice to address issues where appropriate.

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

Overall we rated this service as good for well led because:

- The service had a risk register in place identifying a rating, control measures and an action plan.
- The service 'put patients first'. This was reflected in what we saw and what staff, patients and carers told us.
- Staff morale was generally high with a good understanding of the trust vision and behaviours.
- Patients were happy with the service they received.
- Managers engaged with staff and staff told us they felt well supported. Managers were approachable and accessible.
- There were clear signs of improvements and enthusiasm to make changes in the service.
- The service demonstrated a commitment to work with other agencies to improve the lives of vulnerable people living in the community.

However:

- Improvements were needed to the governance and risk management arrangements due to recent re-structuring, as these were not robust in some teams at the time of our inspection. Managers were aware of this and an action plan was in place. A new member of staff had recently been recruited to assist with this improvement work.
- Some staff were anxious about the future.
- Staff felt at times very senior managers in the trust did not understand the pressures placed on community staff.

Detailed findings

Service vision and strategy

- The trust had a vision of 'together we will deliver outstanding compassionate care to the communities we serve'. All staff we spoke with were aware of this vision.
- We saw posters with the trust vision and values represented by four pillars around the locations we visited. These posters portrayed the trust values of 'putting patients first', 'we "go see"', 'we work together to get results' and 'we do the "must dos"'. Staff we spoke with could relate to these behaviours and were able to give examples of how they were achieved.
- Staff also told us they were aware of the trust's five year strategy and what the service wanted to achieve.
- Work had been identified for the vanguard pilot in the Upper Valley area and there were plans to move forward with this.
- After a 26 month pilot The Quest for Quality team had recently been commissioned as a main stream service.

Governance, risk management and quality measurement

- There had been recent changes in reporting systems for risk management and governance in the trust and in the community division.
- A community services patient safety and quality board meeting was held quarterly and this linked to the trust wide quality committee.
- There was a significant amount of data for community services that were being used to measure the effectiveness and responsiveness of the service. However, this was not available in one report. Managers were working to coordinate all of the data to improve their ability to manage the service.
- There was a separate section in the monthly trust board integrated performance report for community services. This included information about patients with a care plan, leg ulcer healing rates, therapy referral to treatment times and community acquired pressure ulcers.
- The risk register dated 1 December 2015, showed 13 risks for community adults' services. One of the major risks was a failure to meet minimum standards for CQC registration. This was a generic risk with a clear action plan following a mock inspection. Ten risks were rated as moderate, one as minor and one as insignificant. Action plans and control measures were in place to address all the risks identified.

Good

Are services well-led?

- We saw minutes from team meetings and saw that findings from audits were discussed. In some teams this was not robustly managed. There were no timescales or action plans attached to some minutes so staff did not know what was required to make improvements.
- The recent appointment of a health and safety lead to the community division was welcomed by staff and they hoped this would help them make improvements.

Leadership of this service

- A new management team had recently been re-structured and included interim and newly appointed managers in post.
- Senior managers felt the new management team had a lot to do in order to establish robust risk and governance processes, as well as assessing and managing divisional responsibilities.
- Staff told us that overall they felt supported by their direct line manager but more senior managers did not always understand the pressures in the community. However staff had appreciated the interest and concern shown by senior managers in the aftermath of the serious river flooding. The flooding had affected a number of communities in the locality, which had placed pressure on staff in meeting the needs of patients in the affected areas.
- The team leaders of district nursing teams met quarterly with their managers and feedback from these meetings was given to staff at handovers.
- Staff were invited to give their views on the future of the service. We saw evidence of this in team meeting minutes.
- Some staff had required additional support in adopting the new agile way of working. Managers had recognised this was a need and addressed it.

Culture within this service

- One member of staff who was new to the organisation stated it was refreshing to work for an organisation that put patients first. Another staff member said the trust was forward thinking and valued the staff.
- Most staff we spoke with were happy in their work and generally thought that staff morale was high. They also said there was a culture of support and openness and they felt able to raise concerns.
- We observed staff working well together with positive relationships in the multi-disciplinary team. We also observed good working relationships with staff in the local authority and independent sector. This was evident in the SIT and also in the intermediate care teams. There was commitment demonstrated by staff to deliver a seamless service to patients.
- There was some anxiety amongst staff about the future, particularly in relation to the recent tendering process for community services in the Huddersfield area.
- Staff were resilient and determined to meet the needs of their patients, even when faced with difficult circumstances such as the winter floods and snowy weather conditions.

Public engagement

- The trust was organising a public consultation process about re-configuration of services in the area at the time of our inspection.
- Friends and Family test results show that up to January 2016, 87.5%% of the public who had used an adult community service would recommend it. This was below the trust target of 96.2%.
- The response rates for the Friends and Family test were very low. For example the response rate for district nursing services was 1.5% in August 2015.
- Senior managers were committed to improving the response rate to the Friends and Family Test. Patient questionnaires were given to patients at specific intervals during their care pathway. Other means of improving the response rate included the use of text messages, postcards and voicemail. This had seen an increase in some services such as the continence advisory service's response rate being 24.1% in January 2016 and 8% in August 2015. The district nursing service response rate had increased to 14.5%
- It was hoped by managers this approach would result in information going to the individual team it related to, so responses would be more meaningful.

Staff engagement

- The trust was striving to improve the integration of community services into the organisation. Staff told us they were starting to feel more involved and engaged in trust developments. They also acknowledged that the recent re-structuring was a positive step to improve this further.
- Some staff told us about the staff engagement sessions the trust had held. They said these were difficult to attend due to a shortage of staff.

Good

Are services well-led?

- During the inspection we held focus groups with staff and they were positive about the trust and generally expressed they were happy to work in the service. They also said that they felt listened to and were encouraged to put forward ideas.
- Staff did not always feel fully connected to the acute hospital part of the trust. They told us the community service were often not fully understood by the hospital based staff and managers.
- Some staff expressed anxiety about the future, because of expected changes and the large scale change to community services that had occurred the previous year.
- Friends and Family test results from November 2015, show that 77% of staff would recommend this service as a place to received care and treatment. The results also showed that 49% of staff would recommend the service as a place to work.
- Some staff reported that communication channels were sometimes confused and they would receive the same e-mail from several sources.

Innovation, improvement and sustainability

- One area in the locality was to be developed into a pilot vanguard site where localities were to take a national lead in transforming health and social care in the future. This involved a collaboration of health and social care commissioners and providers developing a new model of care. Staff working in this area were motivated and looking forward to the development.
- The future of the service included the formation of health and social care hubs with staff working away from staff bases with the technology to support this more agile way of working.
- The Quest for Quality team in conjunction with the local clinical commissioning group were shortlisted for a Health Service Journal award last year.
- Senior nurses in the district nursing teams including the out of hours service had been trained to verify death in the community. The staff felt this was a very positive step because families did not have to wait for this procedure to be carried out by an unfamiliar out of hour's doctor.
- Work with the ambulance service was planned in order to reduce the number of patients in care homes being taken directly to the emergency department at the acute hospitals.
- Partnership working with the local fire and rescue service had commenced. Vulnerable patients could be referred electronically by the community staff for a fire safety check.