# Locala Community Partnerships C.I.C.

1-256729774

# Community health services for adults

## Quality Report

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Date of inspection visit: 11-14 October 2016, 27 and 28 October 2016 and 4 November 2016
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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) |
|---|---|---|---|
| 1-285685765 | Batley Health Centre | Community adults service | WF17 5ED |
| 1-285685717 | Beckside Court | Community adults service | WF17 5PW |
| 1-285685809 | Cleckheaton Health Centre | Community adults service | BD19 5AP |
| 1-584666529 | Dewsbury and District Hospital | Community adults service | WF13 4HS |
| 1-285685783 | Dewsbury Health Centre | Community adults service | WF15 4HN |
| 1-285685995 | Fartown Health Centre | Community adults service | HD2 2QA |
| 1-285685937 | Holme Valley Memorial Hospital | Community adults service | HD9 3TS |
| 1-285685801 | Princess Royal Health Centre | Community adults service | HD1 4EW |

This report describes our judgement of the quality of care provided within this core service by Locala Community Partnerships C.I.C. 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 Locala Community Partnerships C.I.C and these are brought together to inform our overall judgement of Locala Community Partnerships C.I.C

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

Overall, we rated this service as inadequate because:

- There were significant nursing and therapy staff shortages in the integrated community care teams, which were having an impact on patient care. There were concerns about the lack of robust governance, oversight and monitoring of this situation. There was also a lack of robust governance in relation to incidents and concern about the lack of learning from incidents. The service demonstrated some evidence based care in the various teams and performance against some national and locally set targets was good. However, there was a lack of benchmarking of performance both within the organisation and externally. There was no clinical supervision of nursing staff within the integrated community care teams and the appraisal rates were low. The systems for checking staff competencies were not robust.
- There were a number of services with waiting lists of patients requiring assessment and treatment. There was no dementia strategy and there was a lack of provision for people who did not have English as their first language. However, the service had a range of specialist services to meet the different needs of people in the locality.
- Risk management and governance processes were not robust and plans to improve services were often not in place or lacked deadlines for actions to be achieved. There had been a lack of staff engagement at a time of significant change in the service. Planning for the changes had not been robust and action plans for this did not include actual or potential risks. There were gaps in policies and guidance for staff and there was little oversight or audit to ensure policies were followed. The recovery plans to address waiting lists were not robust and in some situations there were no plans in place to recover the position. Senior managers were not visible to staff and many staff felt they were not listened to. However, there were positive messages from some staff who enjoyed working for the organisation. There were some innovations in working with the third sector.

However:

- Staff in all teams were working very hard to provide a quality service to patients and their carers or families. We saw examples of outstanding care in some services. We saw patients and relatives were treated with dignity, respect and compassion. We observed staff reassuring patients and relatives and there was an empowering approach to patient care in some services. Feedback about the staff and the service from patients and families was mostly positive.

# Summary of findings

## Background to the service

Locala Community Partnerships is an independent community interest company providing NHS community services to over 400,000 people in the Kirklees area of West Yorkshire and beyond. Most of the care and support is provided at home and in clinics, schools and health centres by teams of health visitors, district nurses, therapists and other health care professionals.

There were four business units in the organisation, two of which were responsible for the provision of adult community services. The integrated adults business unit was responsible for therapies, community matrons, end of life care, diabetes, heart failure, respiratory, cardiology, IV therapy, continence, care home support, community in-reach, single point of contact and the out of hours service as well as integrated community care, including planned and unplanned care. The well-being business unit was responsible for the delivery of podiatry and day surgery, including foot surgery and minor plastics, dietetics, neurology and dermatology.

The district nursing teams and therapy teams were an integral part of the integrated community care teams (ICCT). These provided both planned and unplanned care in five localities (Spen and Batley ICCT, Huddersfield (central) ICCT, Dewsbury ICCT, Dearne Valley ICCT and Colne Valley ICCT). The teams provided integrated and co-ordinated care to patients who were housebound, temporarily housebound or were receiving care by a specific care pathway, such as early hospital discharge, rapid response or palliative care. From 1 April 2015 to 31 March 2016, district nurses made 463,057 visits to patients. The ICCTs provided adult nursing services and therapy services including wound care, palliative care support, specialist treatment, crisis management (rapid response) and rehabilitation. The organisation had secured a 'care closer to home' contract to provide services designed to prevent hospital admission and facilitate early hospital discharge. This was implemented in October 2015.

The service worked closely with other health and social care professionals in the locality and had links with voluntary organisations.

Community matrons in the service managed patients with high-risk long-term conditions in the localities. They assessed and recommended appropriate management plans to ensure the patient maximised their independence and managed their own symptoms. This service was available Monday to Friday on a 9am to 5pm basis.

The day surgery service at Holme Valley Memorial Hospital undertook procedures requiring local anaesthetic in specialities such as dermatology, podiatry and muscular-skeletal and plastic surgery.

During our inspection, we visited a number of integrated community care teams, therapy teams, podiatry, day surgery and some specialist services. We also looked at how patients were cared for at end of life. The services we inspected included:

- The community in-reach team
- Intravenous therapy team
- Continence service
- Rehabilitation team including the Jubilee rehabilitation clinic
- Integrated Community Care Teams (ICCTs), including the out of hours integrated service
- Diabetes nurse specialists
- TB nurse specialists
- Respiratory nurse specialists
- Day surgery
- Tissue viability nurse specialists
- Single point of contact (SPOC)
- Community matrons
- Foot health/podiatry
- Cardiology
- Care home support team

As part of this inspection, we spoke with 28 patients and their relatives, 82 nursing staff and therapists and managers of the service. We also looked at 28 care records of patients and visited staff bases across the area. We have reviewed performance information from and about the organisation.

# Summary of findings

## Our inspection team

Our inspection team was led by:

**Chair:** Carole Panteli, Director of Nursing (retired)

**Team Leader:** Berry Rose, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a safeguarding specialist, a governance specialist, professional lead nurse for children's integrated therapy and nursing service, district nurses, a community matron and an occupational therapist. Additionally, there was an expert by experience who had experience of community health services.

## Why we carried out this inspection

We inspected the following community health services as part of our comprehensive community health services inspection programme:

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

## How we carried out this inspection

Locala Community Partnerships CIC provides a range of primary care and community services. These are GP services, community health services (as listed below), sexual health services and primary dental care. We didn't inspect all of these services in October and November 2016. In October and November 2016 we inspected the following community health services provided by Locala Community Partnerships CIC:

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

We have not rated Locala Community Partnerships CIC as a provider for each of the five key questions or given an overall rating because we did not inspect how well-led the organisation was in relation to all the services that it provides.

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

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

Before visiting, we reviewed a range of information we hold about the four community health core services that we inspected and asked other organisations to share what they knew. We carried out an announced visit from 11 to 14 October 2016. We carried out unannounced visits on 27 and 28 October 2016 and 4 November 2016. During the announced inspection we held focus groups with a range of staff who worked within services we inspected including nurses, therapists, doctors and support staff. We also interviewed senior staff in each of the core services we inspected and executives. We talked with people who use the services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who used the services.

# Summary of findings

## What people who use the provider say

We spoke with 28 patients and eight relatives during our inspection. We also had information sent to us prior to the inspection.

Most patients were happy with the service they received. There had been complaints about the delay in reaching the single point of contact earlier in 2016. However, this situation had improved with additional staff and capacity to cope with the demand.

## Good practice

We observed outstanding patient care being delivered in the community rehabilitation team and in the IV home support team. Staff demonstrated holistic care and were very engaged with the needs of the patient and their family.

## Areas for improvement

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

**Action the provider MUST take to improve**

- Ensure that there are robust procedures in place to ensure that incidents, including serious incidents are correctly identified and reported and are comprehensively investigated and reviewed at an appropriate level within the organisation.
- Ensure that learning from incidents and complaints is shared and embedded across the organisation.
- Ensure that the duty of candour process is effective and embedded in practice across the organisation.
- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff, taking into account patients' dependency levels.
- Ensure that all staff have completed mandatory training and role specific training.
- Ensure that infection prevention and control policies and procedures are reviewed and in date.
- Ensure that the infection prevention and control audit programme is followed and actions are identified and implemented in a timely manner when issues are identified through the audit programme.
- Ensure that staff are up-to-date with appraisals and staff attend clinical supervision as required.
- Ensure that there are in operation effective governance, reporting and assurance mechanisms.
- Ensure that there are in operation effective risk management systems so that risks can be identified, assessed, escalated and managed.
- The provider must have systems in place, such as regular audits of the services provided, to monitor and improve the quality of the service.
- Ensure that staff have undertaken safeguarding training at the appropriate levels for their role.
- Ensure that there are appropriate systems in place in the community adults service to ensure that patients are prioritised and seen promptly in accordance with clinical need. In addition, the provider must ensure that the governance and monitoring of such systems is operated effectively to enable the identification of any potential system failures, and to take action so as to protect patients from the risks of inappropriate or unsafe care and treatment.
- Ensure that staff competency is robustly assessed in the community adults service.

**Action the provider SHOULD take to improve**

- Undertake a review of the needs of the local population.
- Review the connectivity issues for mobile devices.

Locala Community Partnerships C.I.C.

# Community health services for adults

**Detailed findings from this inspection**

Inadequate

## Are services safe?

By safe, we mean that people are protected from abuse


**Summary**

We rated safe as inadequate because:

- There was insufficient nursing staff to manage the workload in the integrated community care teams.
- Staff sickness levels in the integrated community care teams were higher than the national average.
- Staff were not provided with guidance or systems to keep patients safe. This included a lack of up to date policies and standard operating procedures.
- Although there were systems in place to report incidents, there was a lack of understanding of incident grading.. There was also a backlog of incidents awaiting investigation. The systems in place to ensure staff learned from incidents were not robust. Senior managers were aware of this but the action plan to address this was also not robust.
- The service identified there were a high number of medication errors, some of which involved insulin administration and controlled drugs. This was a risk to patient safety.
- There was a lack of consistency in the application of the requirements of the duty of candour, meaning patients and their families were not treated with openness and transparency if something went wrong.
- There were omissions in patient care records. In particular there were incomplete electronic palliative care co-ordination records for patients who were at the end of life.
- We found out of date emergency equipment in the foot health department at the Princess Royal Health Centre.
- Some equipment was stored in inappropriate places, such as sterile supplies in staff rest rooms, which posed an infection prevention and control risk.
- Only 12.3% staff had received the new lower level of safeguarding children training.
- A patient care and treatment environment we visited was not safe. The design, the signage and the cleanliness were a risk to patient safety.
- The poor connectivity of the IT equipment meant it was not always possible to have the complete patient record available when it was required by staff. This was a risk to patient safety and there was no timescale set for this to be resolved.

However:

- Infection prevention and control practice by individual members of staff was observed to be good.
- We saw good examples of staff assessing and responding to patient risk.

## Safety performance

- The organisation collected safety performance information monthly. This included falls, pressure ulcers and urinary tract infections with catheters. This data covered all services and was not broken down per service for the period 1 April 2016 to 31 August 2016. Overall, there had been a deterioration in harm free care across the organisation with 95% harm free care in April 2016 and 88.7% harm free care reported in August 2016. The average for this period was 91.5% harm free care, against the national average of 92%.
- Data showed pressure ulcer development was improving, with an incidence of 4.8% against and national average of 5.7%.
- We saw in Integrated Community Care Teams' (ICCT) team meeting minutes that weekly safety huddles had been introduced in September 2016 where patients with pressure ulcers were discussed via an electronic communication system. Staff we spoke with thought this was a good idea, as it identified a number of high-risk patients who did not have assessments, care plans or had missing information. However, this had not been rolled out to all localities at the time of our inspection. Staff told us the safety huddles should be happening on a daily basis but lack of staff had prevented this occurring.
- We saw that the day surgery service assessed venous thromboembolism (VTE) risk at the preoperative assessment. This was in line with national guidance.

## Incident reporting, learning and improvement

- The organisation had a policy for the reporting of incidents, near misses and adverse events. All incidents were reported on an electronic reporting system.
- Staff told us they were confident to report incidents and were encouraged to do so. Staff we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents. Staff said they would report missed or deferred visits, pressure ulcers and medication errors. However, some staff said they sometimes did not report staffing shortages, IT connectivity or abusive patients as an incident, as they were too busy to do so. This was not in line with the organisation's policy.
- Incident reports were sent to the relevant manager to investigate. At the time of our inspection this was the band 7 manager in the ICCTs. We were told the Band 6 clinical leads were to receive training in order to undertake investigations in the future.
- Any incidents involving palliative care patients were sent to the end of life care lead to investigate or provide advice and support.
- Senior managers were aware there was a backlog of incidents to be investigated and improvements were needed to the management of incidents. This included root cause analysis investigation of incidents of pressure ulcers. This situation was referred to in the quality report for September to December 2015 and in the undated business unit recovery plan submitted to us during our inspection. At the end of December 2015, for the whole service, there were 77 incidents waiting to be sent to a manager to review, 75 incidents overdue for review by a manager, 137 overdue for final approval by the quality manager. However, the length of the delays and the timescales for this position to be recovered were not recorded in the recovery plan.
- Senior managers in the organisation told us there had been no never events in the service. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Information supplied to us showed there were 172 non-clinical incidents reported between March and August 2016. Most of these (51) were related to IT and communication issues or workload (34). There were 573 clinical incidents reported for the same period. The majority of these (258) were pressure ulcers and medicines management incidents (73).
- There were sixteen serious incidents (those requiring investigation) between July 2015 and June 2016. Most (13) of these were category 3 pressure ulcers, two were category 4 pressure ulcers and one was an administered overdose of insulin.
- There had been a serious incident in April 2016, which involved the administration of insulin. We reviewed the

serious incident investigation report and associated action plan relating to this incident. We saw there were dates for actions to be completed. However, we did not see in ICCT manager's operational meeting minutes or the medicines management committee meeting minutes any further monitoring to ensure the recommendations had been fully implemented in practice.

- Most nursing staff in the ICCTs we spoke with were aware of this incident and the actions that applied to their practice. Staff were able to tell us about additional eLearning available to them after the investigation of a medication error incident. However, there had been 17 subsequent incidents relating to the administration of insulin since the incident in April 2016.
- Between 1 November 2015 and 31 October 2016 there had been 27 medicines management incidents relating to errors in the administration of insulin. The incidents were recorded as missed dose of insulin (11), incorrect dose of insulin (9), incorrect type of insulin given (3), expired insulin given (2), extra dose of insulin given (1) and a near miss (1). We reviewed these incidents more closely and found a number of incidents had been amalgamated making the overall number of individual errors at least 38. These incidents had all been investigated. Reasons for the errors were lack of connectivity to the electronic record, allocation and scheduling issues, for example, where a patient needed more than one visit a day this was not showing on the nurse's workload for the day. Other reasons for the errors had been identified as poor paper records and communication.
- Nursing staff in the ICCTs told us they were aware of the high number of insulin administration errors. They thought the lack of staff continuity combined with poor IT connectivity were the cause. They were aware of the measures required to prevent medication errors occurring as this had been communicated to them by managers.
- We saw the incidence of category 2 pressure ulcers in one ICCT (Spen and Batley) was much higher than the other four localities between April and June 2016 with 43 out of a total of 93 reported. A deep dive had been conducted by the tissue viability nurses to identify the reasons for this. The provider advised us the number of incidences of category 2 pressure ulcers after this was reduced to 33, which was in line with the rates for other similar sized ICCTs.
- In the specialist teams, we saw examples of learning from incidents being discussed and changes to practise being implemented as a result. The community in-reach team had developed protocols to improve communication with wards after an incident.
- We observed incidents being discussed at a team meeting we attended during our inspection. We also saw this on team meeting minutes we reviewed. However, we were told by managers and staff the weekly ICCT team meetings either had been cancelled or were not well attended due to staffing shortages.
- Staff told us about blogs on 'Elsie', which was the organisation intranet system, and "Locala live" which was an weekly staff information and newsletter sent to all staff via email. They said this was a way of keeping up to date with changes and being made aware of incidents. There was no system for monitoring or recording if staff were keeping up to date with communications.
- There was a monthly team talk document for managers, which included information about incidents. We were told this was mandatory for team managers to read and cascade to their team members. However, there was no system for monitoring or recording if staff were receiving information this way when they were on annual leave or absent from work.

### Duty of Candour

- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients or other relevant persons of certain notifiable safety incidents and provide reasonable support to that person.
- Senior managers in the integrated adults' business unit were aware that there was a lack of consistency in the approach of the organisation and staff to the requirements of the duty of candour. Plans were in place to improve this.
- We found some staff were able to describe the duty of candour and what it meant and could describe a situation where it had been applied. Other staff were not able to articulate what this meant and did not have a good recollection of any training they may have received.
- There was a lack of consistency in whether duty of candour training was mandatory. It was not included as an element of the mandatory training data supplied by

the organisation. A training video had been available to staff from April 2016 and 1,194 members of staff had watched this. Some staff told us they thought watching the video was mandatory and said they had watched it in the week prior to our inspection..

- We also looked at the investigation into a serious incident and found duty of candour had been applied. However, this was not done in a timely manner and there were other incidents where the application of the duty of candour was appropriate and had not been applied, such as category 4 pressure ulcers.

## Safeguarding

- The organisation had a head of safeguarding role with two named professionals for safeguarding adults at risk. Some staff we spoke with were unable to name these professionals but were aware of the contact point for advice when required.
- Safeguarding vulnerable adults and safeguarding children training was mandatory. This was split into levels for each topic with clinical staff requiring a higher level of training.
- Information supplied to us showed 12.3% of staff had received level one training for safeguarding children and 3% had received level two training. For vulnerable adults, 91% of staff had received level one training and 94.9% had received level 2 training against an organisation target of 100%. A new training process had been implemented in August 2016, which meant training rates for safeguarding children were low. All staff were required to have completed this training by March 2017. There was no system in place to ensure this would be achieved.
- Staff we spoke with could describe a safeguarding concern and knew the escalation and referral process. Some staff had made referrals to the local authority and were able to tell us about this.
- A serious safeguarding adults incident had occurred earlier in 2016, which highlighted staff not being able to recognise abuse or knowing what action to take. There had also been delays in managers taking appropriate action in this case. There were a number of actions required to ensure patients were protected, including updating the safeguarding adults' policy and providing further training to staff. The organisation's safeguarding adults policy had been updated since the incident investigation.

## Medicines

- The organisation had a medicines management team. Staff in the community teams told us they appreciated the support this team was able to provide.
- A number of staff in the community adults' teams were independent prescribers or nurse prescribers. There were also staff attending the training course to become nurse prescribers.
- There were up to date Patient Group Directives (PGDs). We saw these in locality bases, day surgery services and saw that these were consulted by staff with signatures of staff using them recorded.
- There was an outpatient parental antimicrobial therapy (OPAT) service called the IV home support team. This was commissioned in partnership with the local acute hospital trust. Nursing staff with extended skills provided care and treatment to patients requiring antibiotic therapy but who could remain at home rather than be in hospital. There were guidelines for staff and a list of drugs, which could be administered which were approved by the South West Yorkshire Area Prescribing Committee. The team members carried none of these medicines; they were delivered to and stored in the patients' homes.
- In podiatry, local anaesthetic was used for nail surgery. We checked stock and found this to be in date. However, stock was not kept in a locked cupboard as recommended by the college of podiatry and there was no signing out procedure. The room where the local anaesthetic was stored was locked and an entry was made on the patient's record when local anaesthetic was administered.
- The service had a supply of syringe drivers for the administration of medication for patients who were at the end of life. Staff were able to access these and there was guidance for their use on the intranet. However, this guidance was out of date and should have been reviewed in June 2014. Revised guidelines were developed in June 2016 and were under consultation at the time of our inspection.
- Some staff told us they preferred to work in pairs with a patient with a syringe driver in situ. However, staff were not clear what the policy was regarding this. We also saw in ICCT meeting minutes that there was no audit process in place for recording where the syringe drivers

were. It had been noted that five syringe drivers had gone missing. There was no action plan to address this problem and the medicine management committee actions dated September 2016 did not refer to this.

- Some staff had also received training on the use of syringe drivers. The end of life lead told us syringe driver training was included in the new starter induction along with the gold standards framework for end of life care. Other staff received annual updates using the manufacturer's ELearning module but this was not mandatory. We did not see any data regarding the number of staff trained. One member of nursing staff told us they had not had their competencies checked.
- Nursing staff were able to access anticipatory medications for patients who were at end of life.
- There were staff who were able to prescribe and good relationships with GPs to ensure patients had medication available should their symptoms suddenly worsen.
- Prescriptions were generated electronically and all details including the prescriber were recorded on the electronic system (SystmOne). Some services did use hand written prescription pads. There was a system in place to ensure the pads were issued to authorised staff and each used sheet was recorded. The use of the prescription pads and of any medicines or products ordered outside the formulary were audited by the medicines management team. We saw in the medicines management committee meeting minutes in September 2016 an action relating to monitoring outside the formulary prescribing but no actions regarding auditing prescription pad procedures.
- We observed good practice in medication administration safety in the home intravenous support team and the ICCTs, with patient identity and drug checking procedures being followed. However, staff told us of a near miss that occurred during our inspection in which a patient could have received two doses of the same medication due to poor communication between two ICCTs. This was reported as an incident.
- We were told by staff and we saw in the scrutiny management group meeting minutes in July 2016, that there were delays in prescription requests being completed and delivered to patients due to the lack of nurse prescribers in the ICCTs. This had resulted in some patients not having the correct wound care products available. We also noted a patient had made a complaint about this.
- There was a plan to ensure all registered nurses had medication administration competency checked as part of the appraisal and development process. However, the appraisal rates were low due to staffing shortages; therefore, this was not being undertaken.

### Environment and equipment

- Community services were delivered in a number of locations across the Kirklees area. Premises belonged to a number of different health and social care organisations in the area as well as Locala.
- We visited the Princess Royal Health Centre, where foot health was delivered. The centre had an unmanned reception desk and unlocked external doors, meaning staff did not know who was in the building. Senior managers were aware of the facilities at this location and had produced an options appraisal of this site for future use and development.
- At the Princess Royal Health Centre, there were unlocked internal doors, which opened directly onto steep concrete stairs. There was signage on the door indicating no entry. However, confused or partially sighted people were at risk, particularly due to the lack of signage in the building overall and the unmanned reception area. We pointed this out at the time of our inspection. On return to the health centre at the unannounced inspection, we found a lock had been fitted to the door at the top and the bottom of the stairs and some temporary signage had been put in place.
- We found two sets of clip removers that had an expiry date of October 2015 at one location. Staff were informed of this at the time of our inspection and they were immediately removed. We found out of date disposable equipment in the ICCT storeroom at Mill Hill Health Centre.
- We found a syringe driver in one locality which was out of date since August 2016. We raised this with staff at the time of our inspection.
- Equipment for patients was provided from an external supplier. Staff reported there was a good ordering and delivery system in place for items such as hospital type beds and pressure relieving mattresses. The out of hours' nursing team staff told us they were able to access equipment for patients, particularly palliative patients, at any time.

Inadequate

# Are services safe?

## Quality of records

- All records for patients were stored on an electronic system called SystmOne. Staff were completely reliant on this system and very few paper records were kept. When patients attended the day surgery service, their paper records were scanned onto SystmOne.
- Some staff told us they used a personal notebook for recording patient details due to the lack of IT connectivity when they were away from their work base. They took responsibility for ensuring this was appropriately stored and destroyed when no longer required. There was no system in place to monitor this.
- The organisation had set a target of 70% of patient records being updated within two hours of the patient contact. Information supplied shows this was achieved in 82% of cases in adult services.
- There were audits on the quality of patient records. Results in the day surgery service showed in August and September 2016, 20% of records had abbreviations used. Other adults' services also reported excessive use of abbreviations, lack of care plans and goal setting, recording of patient consent to share records and consent to treatment. Most services had an action plan with timescales to address these issues.
- We looked at 28 patient records during our inspection and found them to be individualised and mostly complete.
- There was a separate electronic record for palliative care called the electronic palliative care co-ordination system (EPACCS). This was used to record ongoing patient interventions and care in the end of life stage. We looked at care records for eight end of life care patients in one ICCT and found care plans for the syringe driver in use. However, the EPACCS was not completed and a palliative care plan including the patients' preferred place of care was not completed. In another ICCT, we looked at 12 records for patients with end of life care plans. Six of these did not have the care plan fully completed and four had no carers' needs assessment completed. This meant patients who were at the end of life did not have a detailed care plan specific to their needs.
- Do not attempt cardiopulmonary resuscitation (DNACPR) was recorded on the electronic patient record system in the high alerts section on the first page, so this would be visible to anyone who accessed the patient's record. We observed this on the records we reviewed.
- In the day surgery service, we saw patients' records were locked in filing cabinets, which were in a locked room, which protected patient confidentiality.

## Cleanliness, infection control and hygiene

- There was one part-time senior infection prevention and control (IPC) nurse in post. Due to workload, there had not been IPC audits in all high-risk areas. This had been escalated to senior managers as a concern and there were plans to recruit an additional IPC nurse. There were hand hygiene champions in the teams but no IPC link workers.
- The organisation was able to access the daily situation report in relation to infection outbreaks in other organisations and locations across Kirklees. This meant IPC staff were able to ensure appropriate measures were taken when patients moved from one location to another.
- The integrated adults' business unit carried out peer-assessed infection control audits on a quarterly basis. Results showed there was non-compliance in some areas. For example, between July and September 2016, 28 staff (3.7%) were non-compliant with hand hygiene. However, overall compliance on the submitted audits was 96.3%.
- There had been an improvement in the number of infection control audits submitted by the teams in the integrated adults' business unit in the last year. Between October and December 2015, 55.3% were not submitted and between July and October 2016, 33.3% were not submitted. Senior managers were aware of the response rates and the compliance level and this was recorded on the business unit key opportunities, risks and successes document, which functioned as the service risk register. There was no timescale for improvement but an action was to promote peer assessment.
- At the Princess Royal Health Centre foot health clinic we found couches in clinical rooms with tears in the coverings. This was identified in an infection prevention and control (IPC) audit on 31 May 2016. A review of all couches in the organisation took place following this audit. On 10 September 2016, an order was placed for a number of new couches. While waiting for replacement couches paper roll was used to cover tears. When we returned on our unannounced visit, we were told the new couches were arriving later that day.

Inadequate

# Are services safe?

- At the same foot health clinic there was one toilet, used by male and female patients and staff. This is not best practice for infection prevention and control or staff privacy and dignity.
- We found sterile equipment supplies stored on a table in the staff rest room at the foot health clinic. These were not in a cupboard or in a clinical area. This was raised with staff at the time of our inspection. On our return visit we found these items had been moved to a more suitable storage area, but a member of staff had left their personal possessions in this storage cupboard. The manager advised us that these would be removed.
- At the time of our inspection, there was no hand gel available for patients and visitors to use in the foot health clinic at the Princess Royal Health Centre. When we returned for the unannounced inspection there were newly fitted dispensers on the walls in the entrance and in each treatment room. However, they were empty, as the hand cleansing gel had not been delivered.
- There was a lack of cleaning rotas in the foot health clinic. This had been identified in an audit in May 2016 but the action plan we saw did not indicate this had been addressed. On our unannounced inspection, we saw a checklist had been devised for cleaning and implementation was planned for November 2016. There was also no IPC re-audit date planned for this location.
- Nail surgery and diabetic wound care was carried out at the foot health clinic. There was no ventilation in the treatment rooms, which is not best practice. The floors in the clinical rooms at the foot health clinic did not have sealed floor covering which made physical cleaning difficult. Senior managers were aware and this was identified as an action for any future refurbishment of the clinic area.
- Instruments used in foot health and in day surgery were decontaminated off site. Collections of used instruments and delivery of sterilised ones occurred daily Monday to Friday.
- Chairs in the waiting area at the diabetes clinic did not have wipe clean surfaces and the sink taps were not the non-touch type. This is not in line with national IPC guidance.
- We observed staff wearing personal protective equipment and using hand-cleansing gel appropriately in clinic areas and in patients' homes. This equipment was available for all staff to use.
- We observed good IPC techniques implemented by staff during clinical care and treatment.
- We saw appropriate waste segregation at the foot health clinic and at the diabetes clinic. There had been some concerns raised about the disposal of clinical waste in the ICCTs earlier in the year. This had been addressed with further guidance to staff and the appropriate waste segregation bags being available. We observed appropriate waste handling on visits to patients' homes.
- All patients attending the day surgery service were screened for Methicillin Resistant Staphylococcus Aureus (MRSA) at pre-operative assessment clinic. There were no exclusion criteria for screening. However, there was no audit to check all patients had been screened prior to their surgical intervention. Staff were aware of what to do if a screening test result was positive.
- The vascular access devise management policy was awaiting approval. We observed staff in the intravenous home support team were working safely without a policy.

### Mandatory training

- Mandatory training was obtained by staff via eLearning and face-to-face training. There were a number of topics covered in this training including health and safety, fire safety awareness and fraud awareness. We were informed by managers that the way mandatory training compliance was measured had changed from April 2016. Previously staff had reverted to 0% compliance at the start of the year but at the time of our inspection staff were in transition from 0% compliance from April to a rolling programme. Information supplied to us showed overall compliance rates were 76.5%in the integrated adults business unit and 71.4% in the well-being business unit. Managers thought these rates were on target to achieve 100% by the end of March 2017. However, we were told there had been problems with the electronic staff records in the organisation, which had affected the number of staff who could access the on line training modules. Moving and handling training was not on the mandatory training schedule supplied to us by the organisation. However, staff told us this was mandatory and was delivered as a practical training session. We were not supplied with information for compliance with this training.
- Information governance training was mandatory and 80.1% of staff had undertaken this training against an organisation target of 100% by the end of March 2017.

Inadequate

# Are services safe?

- Infection control training was mandatory and 83.3% of staff were compliant with this training against a target of 100% by the end of March 2017.
- Basic life support training was mandatory for all clinical staff and 68.1% of staff were compliant with this training against an organisation target of 100% by the end of March 2017.
- Risk assessment training was mandatory and staff were 60.2% compliant against an organisation target of 100% by the end of March 2017.
- Staff told us they received emails to remind them that their mandatory training was due. Managers were sent spreadsheets advising them of team members' compliance. We saw an email had been sent to all staff in April 2016 from the director of workforce and transformation, indicating non-compliance with training would be considered a disciplinary matter. Staff and managers in the ICCTs told us attending and completing mandatory training was a challenge due to the current staffing levels.

## Assessing and responding to patient risk

- There was no resuscitation equipment stored in the foot health clinic at Princess Royal Health Centre. In an emergency, a defibrillation kit was available in a different department a short distance away. Staff knew they would need to call an emergency ambulance if there was an emergency. However, there had been no drills or simulations arranged for staff.
- In the foot health clinic at Princess Royal Health Centre there was one anaphylaxis kit. Some staff we spoke with did not know where this kit was stored. When we asked where this was, it took a member of staff about five minutes to locate it. The kit was out of date with the expiry date of 1 October 2016. This was pointed out to staff at the time and on our return, we found the kit had been replaced and there were now two kits available. A medicines audit in 2014 had identified more than one anaphylaxis kit was required at this location. There was no evidence this recommendation had been acted on or any further auditing had taken place.
- A risk assessment tool was used to identify patients who were at risk of developing pressure ulcers. We reviewed 28 patient records and found these had been completed. We saw there were care plans in place for patients with pressure ulcers in the records we reviewed.
- Safety huddles to discuss patients with pressure ulcers had recently been implemented in two ICCTs and there were plans for this to happen across all localities.
- We observed a sepsis checklist and cannula reviews in the records of patients who were receiving intravenous antibiotic therapy. We also observed staff taking anaphylaxis kits into the homes of patients receiving this treatment. This was in line with good practice guidelines.
- Daily visual infusion phlebitis (VIP) scoring was undertaken in the intravenous home support team on every patient contact. This was in line with good practice guidelines.
- Patients on the community matrons' caseload were given rescue packs for their specific condition in order for them to self-manage symptoms and prevent hospital admission.
- Staff in the ICCT and the out of hour's integrated service contacted patients by telephone during the course of the day, or evening, if scheduled visits needed to be changed. Assessing the patient's immediate needs were part of this in order to determine priority visits.
- Patients' risk assessments were colour coded on SystmOne, which had visual impact.
- In the day surgery service, the safer steps to surgery principles were used. This included preoperative list safety huddles for all staff. There was a policy for safer standards for invasive procedures. This was available to staff on line and had been updated in July 2016.
- The day surgery service had just commenced a programme of auditing safer surgery procedures. An audit completed in August 2016 showed 88% compliance. There had not been a theatre list available to staff in the procedural area, which reduced the score. The ward manager was aware of the audit results.
- The WHO Surgical Safety Checklist was used in the day surgery service. We checked a patient's record and found this had been fully completed. The service conducted patient records audits, which included compliance with the WHO checklist.

## Staffing levels and caseload

- The vacancy rate for the adults' business unit in September 2016 was 8.6% and in the well-being business unit it was 6.9%. The vacancy rate for nursing staff was 7.7% and for allied health professionals it was 10% across both business units.

Inadequate

# Are services safe?

- Staff sickness absence levels in the ICCTs were 7.2% from April 2016 to September 2016. This was above the national target of 4% for health care providers. Staff thought there had been an increase in staff sickness absence due to work related stress. The highest rate of sickness absence for nursing staff was in the Batley and Spen ICCT at 10.4%. The lowest rate of sickness for nursing staff was in Dearne Valley ICCT. Sickness absence rates for allied health professional averaged 13.2% for the same period.
- The average staff turnover rates in 2015 – 2016 in the two business units was 1.85%. Senior managers told us there had been a mutually agreed resignation scheme in operation during this time, which elevated the number of staff leaving. Information supplied showed 26 staff left the organisation under this scheme in 2015 – 2016. The average staff turnover in the two business units from 1 April 2016 to 31 October 2016 was 1.2%.
- Staff turnover in the Single Point of Contact was high. Managers were looking at ways to improve this and were introducing career opportunities for call handlers to progress in the role.
- The service used very little agency nursing. Information supplied showed there was 3.6% rate of agency use. Bank staff were used to help fill gaps in shifts.
- The service assessed the staffing situation in the ICCTs on a daily basis and implemented a resource escalation action plan (REAP). Managers of the ICCTs were involved in the escalation plans and senior managers were aware of the staffing problems.
- We reviewed the REAP criteria and actions and saw the trigger point for REAP 3 was a significant unexpected reduction in staffing of 15 – 20% with annual leave at 15, which totalled a staff reduction of 30 – 35%. The trigger point for REAP 4 was a total staff reduction of 35 – 40%.
- We saw nurse staffing levels in the ICCTs up to band 5 were consistently causing a high REAP score daily (3 or 4 out of 5) in each locality. This had been the situation since the beginning of August 2016 in all the ICCTs. Two localities were at REAP level 5 during the week of 24 October 2016 with a nurse staff reduction up to band 5 of more than 40%. We were told by staff, and saw in the information supplied, that the reason for the high REAP levels was due to the combination of staff vacancies and sickness absence.
- Senior clinicians such as community matrons and team leaders were providing clinical care when possible when the REAP level was high.
- We noted in the REAP an action to manage the immediate situation at Level 3 was to defer non-urgent visits such as annual reviews and routine blood tests. Actions at Level 4 and Level 5 included reviewing all scheduled visits and prioritising urgent cases. However, the REAP document did not offer any guidance for staff regarding prioritising already deferred visits from previous days. There was no other formal guidance provided to staff about this situation.
- The district nursing service in the ICCTs had been split into planned care and unplanned care teams. Rapid response work was included in the unplanned care team. The ICCTs were then sub-divided into zones.
- The district nursing service hours were from 7:30am until 10pm. There had been a recent introduction of a twilight shift from 12:00 to 8pm to help with the unplanned work demand.
- There was no qualified therapy staff working in the ICCTs at weekends. Rehabilitation assistants carried on rehabilitation work with patients over the weekends.
- All patient first visits and assessments were undertaken by a registered professional. The health care assistants would be allocated patients who were assessed and had a care plan in place.
- The Band 6 district nurse clinical lead in the ICCT would allocate the planned workload to team members up to two days in advance, with later, unplanned or more urgent referrals being added when they were received. The additional visits would be communicated to team members via the electronic system.
- Caseloads for each ICCT locality ranged from 866 patients in Colne Valley to 1,346 patients in Central with a total of 5,577 patients on the caseload at the end of September 2016. There was also an inactive caseload, which included patients who had been admitted to hospital.
- Information showed, and staff told us, that the number of patient visits for nursing staff was approximately 15 – 20 per shift. Staff said it was difficult to fit in this number of visits in the shift. Staff told us they worked on their laptops at home to complete patient records and were working many hours more than they were contracted for.
- The ICCT team leaders told us timings for visits were 20 minutes as a guide. Patients with more than one care plan should be allocated more time but managers and nursing staff in the ICCTs said this was unrealistic with the current staffing levels.

Inadequate

# Are services safe?

- We spoke with 17 district nurses during the inspection. Ten district nurses told us the current workload was difficult to manage. A significant number of the nurses we spoke with were in tears during the inspection due to the pressure of the workload, which they said had been the situation for several months. For example, we saw the diary of one Band 5 community nurse. They had worked at a leg ulcer clinic in the morning and had 14 visits allocated in the afternoon on one day in October.
- We reviewed other information on staff workload and saw between 1 July 2016 and 30 September 2016 there were 220 occasions when staff had 20 or more visits in a shift. However, this data did not indicate the length of the shift worked. Further analysis has been provided by the organisation which showed over 65% of the shifts with more than 20 visits were over eight hours long. Other data supplied has demonstrated an average number of visits per eight hour shift between 1 July and 30 September 2016 as 14.3, which is within the national average benchmark. However, the complexity of the patients' needs and travelling time was not included in this analysis.
- The out of hour's integrated district nursing service covered from 10pm to 8am. There were four teams covering the whole area with four registered nurses including a team leader, four health care support workers and four care workers who were employed by the local authority adult social care department. The band 6 registered nurse was responsible for allocating work to the integrated team members overnight. Some visits were delayed and handed over to the day staff. This was done on a priority basis and after contact with the patient or their family. An on-call manager was available to be contacted out of hours to escalate concerns.
- In podiatry, there were 10,361 patients on the Huddersfield caseload and in North Kirklees, there were 12,289 patients on the caseload. This was a total of 22,650. Staff told us this caseload was difficult to manage with their current resources.
- There were 900 patients on the diabetes nurse specialist team caseload. The team consisted of 5.2 whole time equivalent staff including specialist nurses and administration support working 8am to 9pm, seven days per week.
- There was no formal acuity and dependency tool in use to help with planning workloads in the ICCTs. There was a colour-coded system for patient visits. The more urgent and more complex patients showed as a different colour to routine or less urgent patients on the system. This assisted the Band 6 clinical leads to allocate work to staff equitably and match the skills of staff to the needs of the patients as well as identifying those patients requiring a rapid response visit. There was no formal guidance to support staff in work allocation. The clinical leads used their own judgement when allocating the workload based on knowledge of their teams competencies and of the patient's needs.
- Therapists and nursing staff told us it was sometimes very difficult to arrange joint visits with team members due to pressure of workload and with local authority adult social care staff due to the rurality and shortage of staff.
- Senior managers told us there had been consequences to focussing on bidding for a significant service contract, which came about in October 2015. They recognised this had affected the ICCTs and there were challenges in delivering the new service model. Staff told us several members of the district nursing teams and therapists had left because of the significant changes in service and they thought staffing levels had not been restored.
- There was a recovery plan for the ICCTs. This was developed by senior managers in response to staff raising concerns about capacity in the teams to manage the workload. We asked to review the recovery plan at the time of our inspection. The plan included identifying the needs of the population in each locality; understanding the capacity available and how to manage this better and check staffs' competencies and capabilities. There had been some progress recorded on the action plan but the timescales for completion of other actions was not clear. It was also not clear what was required for an action to be completed. For example, the staff training needs analysis against core competencies had no dates in the update column and the action was not complete.
- We reviewed minutes of the Scrutiny Management Group and the Finance Performance and Quality Committee. They showed that the staffing issues in the ICCTs had been escalated and a number of actions had been agreed to address them.
- We were told some band 3 health care support workers were trained to support the registered nurses with tasks such as catheter changes and injecting medications. A competency package for this training had been developed. However, the health care support workers

told us they had not been regraded at a higher level with this additional responsibility. Managers told us this additional responsibility had been assessed as being appropriate within the current grading at band 3. Some staff had been employed at band 2 and moved to a band 3 after completion of the training and achieving the competencies.

- We were told staff were working additional hours, some were being paid overtime and coming into work from annual leave to help manage the staffing shortfalls. Staff from specialist teams and community matrons were also assisting the ICCTs to meet the demand. One manager was working a clinical shift at the time of our unannounced inspection due to severe staff shortages. These responses to operational pressures were outlined in the REAP plan. However, staff told us this was not sustainable.
- The staff in the integrated out of hours team told us there had been an increase in the number of visits being passed to them from ICCT staff who were working in the evening. Information supplied to us showed there were 136 in July 2016, 117 in August and 114 in September. However, 82% of these handed over visits were undertaken before 11pm. Senior managers were aware of this and were looking at different patterns of working for day and evening staff.
- Senior managers told us they were working to improve the staffing situation with on-going recruitment and moving staff from teams to assist. However, managers also told us recent recruitment campaigns had not seen many applicants. Managers told us they were also looking at a skill mix review, contracts with more flexibility regarding hours of work and incentive schemes to attract more applicants. This was part of the ICCTs' recovery plan but there were no timescales for this to be achieved. Some staff told us it was not possible to move staff from other areas to assist when each locality was so short of staff. However, we were told by managers that a daily review took place to determine where staff needed to be redeployed to meet organisational pressures as part of the REAP escalation process.
- The adult business unit recovery plan indicated a new system of self-allocation across the ICCTs. A pilot of this had been put on hold due to IT issues. There was a plan to review the lessons learned from the pilot in December 2016. It was not clear from the recovery plan if this was still taking place.
- Community matrons and the ICCTs managers told us that they were assisting colleagues in the district nursing teams to meet the demands on the service. Some community matrons told us they were not district nurse trained and therefore were not able to fully assist with the demand. Community matrons said they were concerned these demands meant their own caseloads were not getting attention and were concerned about the impact of this with winter approaching.
- Slightly higher levels of stress amongst staff were reported in the organisation at 40% compared to the NHS survey results of 37%. The organisation had facilitated stress workshops for staff but had noted the staff who were in need of support had not attended. Staff in the ICCTs told us a number of team members had left due to work related stress or staff were taking sickness absence. However, senior managers told us the sickness coding for anxiety/depression and stress related incidents did not make a distinction between work related and personal stress.
- Managers of the ICCTs told us they had been given more responsibilities, including human resources and finance, as well as having to undertake some clinical work, allocation and prescribing due to the pressure in the teams.
- Staff told us that participating in audit activities was difficult due to staffing levels as it took them away from patient care.
- Staffing levels were not a stand-alone item on the business unit key opportunities, risks and successes document. This was included in the clinical risk. The adult business unit recovery plan identified a need to undertake a fundamental workforce review to assess staffing establishments and capacity. This was due to start in November 2016 but there was no completion date identified.

### Managing anticipated risks

- For several months prior to our inspection locality managers were meeting daily to establish the risk to the service due to the low staffing levels in district nursing teams. There was an escalation plan for the immediate management of this risk. However, there was no plan for the subsequent risks that could occur as a result of the long-term implementation of the escalation plan. For example, routine visits which had been deferred for a long period that could have a detrimental effect on patients.

Inadequate

# Are services safe?

- The integrated out of hours nursing team told us they had access to 4x4 vehicles overnight if the weather conditions were bad. These were supplied and driven by local authority staff. There was an escalation plan for the service in the case of snow. All staff we spoke with were aware of this.

## Major incident awareness and training

- Staff we spoke with were aware of business continuity plans and could give examples of when this might be instigated.
- There had been a serious incident in a locality, which had tested resilience plans during the summer.

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

We rated effective as requires improvement because:

- Although staff were confident about the use of information technology, the hardware and connectivity issues affected the way in which they worked.
- New staff in the integrated community care teams (ICCTs) did not receive a good induction to the service due to severe staffing shortages and a lack of oversight by managers.
- Staff competencies had not been properly checked.
- The staff appraisal rate was low and some staff had not had an appraisal for four years.
- There was no individual clinical supervision taking place for nursing staff in the ICCTs.
- There was a lack of knowledge and recording of patients' mental capacity and deprivation of liberty.
- The pathways of care were not clear in the ICCTs for planned and unplanned care.

However:

- Staff demonstrated evidence based practice.
- Patient reported outcome measures were good.
- Palliative care patients were prioritised and there were good links with the local hospice.

## Evidence based care and treatment

- We saw evidence-based care being implemented in a number of specialist services such as the diabetes specialist service, continence service and the respiratory team. These teams demonstrated use of National Institute of Healthcare Excellence (NICE) guidelines and were knowledgeable regarding the use of this national guidance.
- We saw other examples of evidence-based care in use such as a falls risk assessment, wound care assessment and treatments and end of life care.
- The intravenous home support team were working to the NICE guidance regarding the use of cannulas.
- A recently developed individual care of the dying document had just been implemented. This had been developed in conjunction with the local acute hospital. This incorporated the nationally recognised Gold Standards Framework for end of life care. However, this was not seen to be in use in the palliative care patients we visited with staff.
- The palliative care team were members of the Yorkshire and Humber end of life care facilitators network. . They had been shortlisted in the end of life care champion(s) of the year category at the national council for palliative care national awards in 2015.
- In podiatry, a new scanner was to be obtained in order to meet national guidelines on highlighting patient's pressure points.

## Pain relief

- Nursing staff were able to access anticipatory medications for patients who were at end of life. This included medication for pain relief. However, there was no written explanatory leaflet to give to patients or their families in relation to anticipatory medicines, which is best practise.
- We saw care plans included an assessment of patient's pain and these had been completed. However, a specific pain assessment tool was not in use.
- We observed patients being asked about their pain during contacts with staff and appropriate advice and action being taken when required.
- Staff were able to access advice and support from the local hospice 24 hours a day for palliative patients' symptom management.
- Patients using the day surgery service received information about pain relief at the preoperative assessment and on discharge.
- We saw patient feedback indicating they had been satisfied with the management of their pain. However, there was a complaint from a patient's relative about the timeliness of pain relief medication in June 2016.

## Nutrition and hydration

- We saw nutrition and hydration assessments in all the patient records we reviewed on the nursing caseload. The nationally recognised universal risk assessment for

malnutrition (MUST) was used. However, we were told by staff this was reviewed only if the patient had a high risk of pressure ulcer development, when the MUST was undertaken monthly.
- We observed staff making sure vulnerable patients had sufficient food and drink in reach when leaving their homes after a visit.
- Staff did not report problems referring patients to dietetics or speech and language therapy services.
- Weighing patients in the community was difficult. Care homes were able to do this with the correct equipment. In patients' own homes, unless they were able to stand on their own bathroom scales, an estimate of the body mass index was done. Staff had been trained on how to do this.

### Technology and telemedicine

- All mobile working staff were supplied with a laptop and a mobile telephone.
- The service used technology to enhance the service it provided to patients. This was achieved by using photography, virtual patient contacts and messaging. This meant fewer face to face visits were required and specialists could be involved without having to visit the patient.
- The organisation stated 10% of direct contacts with patients were undertaken by staff using the telephone or through virtual contacts. The organisation was committed to developing this telemedicine service and many staff spoke of the benefits of using it.
- There were significant issues with connectivity of the mobile technology resulting in important patient information being unavailable to staff when they needed it. Senior managers were aware of these issues and were taking steps to improve this. However, there was no timescale for these improvements to be made. Staff had been advised by managers to contact colleagues at the work bases for information about patients at time they could not access it themselves. We saw this happen on several occasions during our inspection.
- Most staff we spoke with were enthusiastic about the use of and developments in technology in the service. They were able to tell us how this improved patient care and was an effective use of resources. However, staff expressed their frustrations about the intermittent connectivity and how this affected their ability to work safely and efficiently.

### Patient outcomes

- The service participated in a number of national audits. For example, the audit of cardiac rehabilitation, the British thoracic biannual audit and the national falls audit.
- The cardiology team were planning to participate in NICE guidelines audit for heart failure drugs and management. This was to be undertaken with the supervision of a consultant.
- The service did not take part in the national intermediate care audit in 2016.
- In the diabetes service and continence service, we saw patients had outcomes measured objectively in relation to impact on their quality of life. For example, general health improvements and what activities they could undertake as well as managing their own condition.
- All services contributed to patient reported outcome measures (PROMS) which showed an overall positive outcome on conclusion of a care episode of 96.3% against a target of 80% between 1 March 2016 and 31 August 2016. The service did not supply details of the number of patients who had responded to this.
- We saw that 95% of patients demonstrated a maintained or improved level of functioning on transfer or discharge from therapy services in August 2016. In the same month, 86% of patients reported confidence in managing their condition on discharge from therapy services.
- We saw measureable and achievable goals being set in conjunction with patients in a number of services such as the community rehabilitation team and the continence service. However, goal setting in other services had been highlighted as an area for improvement following records audits.
- The intravenous home support team had saved 1120 hospital bed days for patients and 88 patients had avoided admission since April 2016.
- Data we reviewed showed that end of life care patients were always seen within zero – 2 hours of the referral being received and were a priority for the staff in the unplanned care team. However, one member of nursing staff told us palliative care patients were not being visited as often as they would like to due to the current staffing levels. We were also told of a palliative care patient whose visit had been deferred and this had resulted in a complaint.

Requires improvement

# Are services effective?

- Other performance data showed 6.8% of patients on the caseloads were readmitted to hospital in September 2016. This was against a target of less than 15%.
- Information supplied to us showed 68.9% of patients who were subject to an end of life care plan died in their preferred place of care in August, where this had been recorded. This was against a target of 45%. The reason for not achieving the patients' preferred place of care was also recorded. However, we found there were gaps in the documentation for some patients on the end of life care plan and the preferred place of death was not recorded.
- Therapy staff described the model of care being very focussed on health education, empowerment of the patient and promotion of self-care. We saw evidence of this in the therapy sessions we observed and the patient visits we attended.
- Community matrons told us there was information captured to show hospital avoidance but there was no consistency in the way it was collected or analysed. This meant patient outcomes and the effectiveness of their role was not fully understood.
- Senior managers were aware the amount and type of information collected regarding patient outcomes was not always used in the most effective way. There were plans to review the way information was gathered in order to improve the service. However, there was no action plan for improvement.
- There had been no recent audits on do not attempt cardiopulmonary resuscitation forms, with the last audit taking place in 2015.

## Competent staff

- New registered nursing staff in the ICCTs had a six-week induction period. During this time, they completed mandatory training and spent time meeting specialist team members such as the tissue viability nurses. However, one new clinical leader told us they had found a number of registered nurses in their team who had been in post for six months who had not had a formal induction. Some staff in the ICCTs told us that their induction had not been good due to staffing levels.
- Band 7 managers and band 6 clinical leads told us there were a high proportion of newly qualified and inexperienced staff in the ICCTs. Band 6 clinical leads expressed concerns about this, as the more experienced team members did not have sufficient time to support them in their new role.
- A band 6 clinical lead told us it was almost impossible to provide the correct level of support and supervision to the inexperienced members of her team as well as manage her own patient caseload.
- A band 5 staff nurse told us they had requested a band 6 district nurse to review a patient but this had not happened, as the senior nurse was too busy with other responsibilities.
- An investigation into a serious incident in July 2016, highlighted a newly employed member of staff did not have a clearly documented induction or a development plan. They also did not have a formal assessment of competence in clinical practice.
- Senior managers told us they were undertaking a review of all the competencies for each grade of staff. They were evaluating what training was required.
- A new band 6 development nurse role had recently been introduced to assist with the identified problems of staff competencies and lack of training needs analysis in the ICCTs. However, we were told by managers there were difficulties in addressing the problems due to the staffing issues.
- Nursing staff told us they had not been able to access any of the available leadership courses due to lack of staff.
- Staff from the specialist heart failure team and the end of life care (EOLC) education team delivered training on an annual basis as part of the long-term conditions update to staff in the ICCTs.
- Training of the use of syringe drivers was given as part of the induction for new nursing staff as well as education on the Gold Standards Framework for EOLC.
- Staff told us that registered nurses undertook palliative care visits unless the health care support worker in the team knew the patient very well. The end of life care lead told us most staff visiting palliative care patients had received training in EOLC.
- Approximately 80 members of nursing staff had completed verification of patient death training.
- Staff in the care home support team had attended study days on chronic disease management. Other staff told us they had been able to access other post registration courses, some of which were fully or partly funded by the organisation.

Requires improvement

# Are services effective?

- Information supplied to us by the service showed the number of staff who had received an appraisal this year was below the trajectory in order to achieve 100% compliance. The position at the end of August was 34.2% compliance against a year to date target of 41.7%.
- Appraisal compliance was variable across the teams. Some teams such as the in reach team had achieved 100% compliance as all four staff had received an appraisal. However, in other teams such as the ICCTs only 23.2% of staff had received an appraisal this year. In one of these teams, only one member of staff out of 47 had received an appraisal. Two members of staff said they had not had an appraisal for more than four years. Others said their appraisal had been booked and then cancelled at short notice. We were told the appraisal documentation had been improved and the process felt more personal and meaningful.
- We spoke with a health care support worker who had been in post for two years and was still waiting for their competencies to be signed off. We saw in ICCT meeting minutes there were band 5 nurses and band 3 health care support workers who were not meeting competency requirements but were not able to be released for training due to staffing levels.
- In September 2016, managers had developed an action plan to address the appraisal compliance rate. This plan did not include ascertaining the number of staff who were trained to undertake appraisals or how a shortfall in the number of suitably trained staff would be addressed.
- Nursing staff in the ICCTs were not receiving any formal individual clinical supervision. This is a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient protection and safety of care in complex clinical situations. Without this process in place, there was a risk of inexperienced staff working outside their competence and managers not being aware of this. We were told by staff there was some group clinical supervision sessions but these were not regular and were not being recorded.
- Managers and staff in the ICCTs told us the shortage of staff meant clinical supervision was not taking place and there was no template developed for the process. However, clinical supervision was taking place in other teams such as cardiology, community matrons and physiotherapy.
- Staff in the unplanned ICCTs told us they were undertaking rapid response work. This was a service designed to assist patients in a crisis and avoid hospital admission. District nursing staff told us they had received no training for this provision and there was no written guidance for them to follow. Some staff said there had been some initial training from the now disbanded intermediate care team to undertake mobility and activities of daily living assessments. Information supplied by the organisation showed this training was given to eight members of nursing staff between January and April 2016. This equated to less than two members of each team receiving this training. Managers told us only therapy staff were undertaking these assessments but nursing and therapy staff said this was not the case.
- Nursing and therapy staff in the ICCTs told us the therapy staff had not been trained to undertake tasks such as wound checks. This resulted in nursing workloads increasing as some patients with wounds required additional nursing visits.
- Some staff told us they were undertaking tasks without having competency in that task signed off. For example, syringe driver changing.
- Most registered nursing staff we spoke with told us they had received the necessary support with the Nursing and Midwifery Council revalidation process. There had been some events held and communications sent to nursing staff. However, some staff said they had not received any support.
- Some staff in the specialist teams told us they had opportunities to attend courses and training. The organisation provided the funding for this but staff reported there were sometimes difficulties in backfilling the member of staff's absence whilst attending the course.
- The four members of the intravenous home support team were assessed annually by a specialist in the acute trust to ensure their competencies were maintained.
- Nurses in the ICCTs had been rotated from the planned team to undertake palliative care visits. This was better for patient care continuity and helped staff maintain staffs' skills.
- A five-year rolling programme of training had been developed for end of life care in conjunction with the

local hospice. The EOLC co-ordinator was about to undertake an evaluation of this. The EOLC co-ordinator did not compile a report for senior managers regarding numbers of staff attending training sessions.
- There were link nurses for diabetes care and for tissue viability. We were told the last link meeting for diabetes had only one attendee out of 20 link nurses.

### Multi-disciplinary working and coordinated care pathways

- Two staff from therapy services in the ICCTs we spoke with told us there were unclear pathways and criteria for patients in determining planned or unplanned care. For example, there was a lack of clarity into which team a cancer patient who had been discharged with stroke like symptoms should be referred to.
- We saw on the integrated adults business unit KORS document there were some identified tasks such as blood tests, wound care and Doppler recordings which were leading to additional demand on the district nurses This was on the adult business unit key opportunities, risks and successes document (KORS) but timescales for resolution with local GPs were not identified.
- The ICCT worked closely with the local authority home care services to provide a seamless service to patients. Staff in the teams and managers told us this was not always achieved due to resource and capacity issues in the local authority.
- There were monthly multidisciplinary meetings with GPs to discuss the Gold Standards framework for end of life care patients. However, staff told us they had not been able to attend due their workload. We saw on the Dewsbury locality team meeting minutes in September 2016 that local GPs had raised concerns with senior managers about this. This is not detailed in the adult business unit KORS.
- Nursing staff and the end of life lead told us there were good professional relationships with the local hospice for palliative care patients. There was a specialist palliative care nurse who staff in the ICCTs could contact for advice and support for patients who were at end of life. The out of hours integrated nursing team described the working relationship with the hospice as 'excellent'.
- Senior managers were aware there was a less effective provision for palliative and end of life care in the north Kirklees area. New plans with commissioners were being implemented to ensure a more holistic service.
- There was an end of life champion in the respiratory service. This ensured a smooth transition into other services when a respiratory patient entered their end of life phase.
- The heart failure nurse specialist had good links with the heart failure nurse in the acute trust and met for multidisciplinary meetings on a monthly basis. The heart failure nurse specialist told us they had provided advice to physiotherapy staff when working with a patient with exercise tolerance issues to ensure the patient received the optimum care and treatment.
- The organisation had good links with the local university with student placements into the service, as well as the university offering courses and training to staff. For example, the skills lab at the university had set up a rolling programme and delivered training to district nurses on verification of patient death. This training had been very well received by nursing staff as they told us this meant a better experience for the families of patients who had deceased expectedly overnight.

### Referral, transfer, discharge and transition

- Most referrals to the integrated adults' business unit teams was via the single point of contact (SPOC). This could be from GPs, hospital staff including consultants, social services, the voluntary sector, relatives and patients. The call handlers triaged the referrals and allocated these to the relevant locality ICCT, service or specialist team. In each ICCT an administrator allocated the referrals to the appropriate clinical lead for each zone. The clinical lead (band 6 district nurse) would then allocate the referral to the most appropriate member of staff in the planned or unplanned teams.
- Specialist services such as the cardiology and respiratory service informed the patients' GP and the hospital consultant when patients were discharged from their service.
- End of life patients were picked up as referrals from the GP multidisciplinary meeting. Existing palliative care patients were also discussed at these meetings. Patients who were at end of life could be referred to the unplanned care teams. The out of hour's integrated nursing team told us they left a gap in the allocation of work in order to accept and visit a palliative care patient should there be a need overnight.
- There was 24-hour access to the local hospice. This included 24-hour advice from a palliative care consultant. It was possible to arrange admission into

hospice care at any time of day or night if a bed was available and appropriate transport could be obtained. The out of hours integrated service gave an example of when this had happened.
- The diabetes nurse specialists were able to refer patients to GPs for weight loss programmes.
- Senior managers told us resource and capacity demands in the local authority social services teams sometimes made it difficult for patient care to be transferred out of the teams resulting in delayed discharges from the service.
- The community in-reach team worked seven days per week to prevent hospital admissions from the emergency department at the local acute hospitals. Patients on this caseload were discharged after 28 days and referred to other services as required.
- Patients on the intravenous home support caseload were subject to a virtual ward round on a weekly basis with a consultant microbiologist from the acute hospital trust.

### Access to information

- The service used SystmOne, which is an electronic patient record. This worked well for staff who were in a base such as a health centre for their work. Staff who were mobile told us and we observed that this was very problematic due lack of connectivity. All information about patients was stored electronically on this system.
- When there was lack of connectivity, staff were not able to access the information they needed. Staff told us there was no facility to download patient information to allow staff access to patient records when connectivity was lost.
- We observed the loss of connectivity was a very frequent occurrence and this impacted on staff being able to use their time effectively because of the number of calls made to colleagues to check patient details and care needs.
- There was an advanced care plan and an advanced care policy for palliative care patients. When we asked a member of staff to show this to us online they were unable to find either of these documents. Some staff told us the advanced care plan, which was a 36 page paper document was often not completed. This was also the opinion of the end of life lead who thought the reason for this was insufficient time and resources to facilitate its implementation. If this was not completed, there was a risk of breakdown of communication with other care providers, such as Marie Curie care workers.
- Some GP surgeries in the locality did not use SystmOne, so staff were unable to access the information held about patients as easily. There was a system in place to obtain patient information from these surgeries. Staff told us the GP surgeries were cooperative.
- Some paper records were kept in patients' homes. This was mostly for end of life patients in order for carers from other agencies, such as Marie Curie, to communicate with the district nurses.
- There were good links between specialist teams and the acute hospitals. For example, the heart failure specialist nurse was able to access specific test results electronically or by telephone to the relevant department.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Most staff we spoke with were able to explain about the need to obtain patients' consent to care and treatment. We saw some examples of this in patient records and in observations of staff interacting with patients.
- In the day surgery service, consent to treatment and procedures was obtained prior to surgery and patients were able to have a cooling off period. Consent was discussed again on the day of the procedure. We reviewed patient records and found this to be the case.
- Mental capacity act training was mandatory and there was 90.8% compliance with this. However, capacity assessments in four records we reviewed of patients living with dementia had not been completed. The band 6 and band 5 nursing staff told us they did not have the knowledge and skills to be confident to undertake a capacity assessment.
- An internal audit of records of five palliative care patients conducted in October 2016 had showed only one do not attempt cardiopulmonary resuscitation (DNACPR) form present. When we reviewed the records of a palliative care patient who was living with dementia there was no evidence of a capacity assessment to support the DNACPR decision. Senior managers informed us it was the responsibility of the community

nurse, community matron or specialist nurse involved with the patient to check the appropriate paperwork was in place and to contact the patient's GP if it was not there.

- In the diabetes clinic, patients were assessed using the mini mental state examination which was commonly used test for complaints of problems with memory or other mental abilities. This was part of the dementia-screening programme in use. We saw staff using this tool to help assess patients' cognitive abilities.
- Senior managers were aware that there were gaps in staff knowledge and the in policy to support the legal requirements of the mental capacity act. This had been identified in audits of patient records. The consent policy had recently been reviewed and was waiting for ratification at the time of our inspection.
- There were 19 end of life champions who accessed training from the local hospice regarding consent, decision making and capacity in end of life patients.
- Some staff we spoke with knew about best interests decisions in the case of patients who lacked capacity to make their own decisions.
- Most staff we spoke with were not able to articulate the requirements of the deprivation of liberty safeguards (DoLS). This meant those staff who went into care homes would not understand the legal framework protecting the patients and those caring for them. However, a face-to-face delivery course had just been commenced and 8.3% of staff who required this training had completed it at the time of our inspection.
- The service had provided a flow chart to staff about the DoLS process.

Good

# Are services caring?

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

## Summary

We rated caring in this service as good because:

- Staff treated patients with compassion and respect. Patients' privacy and dignity was preserved and patients were involved in decisions about their care and treatment.
- There was good rapport between staff and patients, particularly those who were well known to the service.
- Patients and carers gave very positive feedback about the way staff had cared for and treated them. Patients also gave positive feedback about the standard of care they had received.
- There were some examples of outstanding care in some of the specialist teams. Some staff in these teams were able to demonstrate extremely high quality, holistic care to patients and their carers.

However:

- Staff shortages affected the amount of time some staff could spend with patients and their carers and meant that the care was sometimes task focussed.

## Compassionate care

- We saw staff interacting well with patients and their families. Some patients and staff had a long standing patient/professional relationship with a good rapport demonstrated.
- We saw staff giving patients excellent information and explanations about their clinical care and the options for self-managing their symptoms.
- All patients we spoke with gave very positive accounts of their care and interactions with staff. They said staff had respected their privacy and dignity. One patient receiving care from the nurses in an ICCT was "absolutely amazed what the care had been like. Every single nurse that had been in and the care they have given".
- We saw comments on the Locala patient opinion website indicating staff had demonstrated a professional, kind and caring approach to patient care.
- In the diabetes clinic, staff had deliberately not put clocks on the wall, so patients did not feel they were being rushed and staff had time for them.
- We were given an example of outstanding care from a patient who was given a hair wash by staff from the intravenous therapy service. This team had also taken the patient's nebuliser to be cleaned and liaised with the respiratory nurse for the patient's equipment to be reviewed.
- Some district nursing staff had received dignity in end of life care training from the local hospice.

## Understanding and involvement of patients and those close to them

- Some district nurses had been trained in the verification of patient death. This was for situations where the patient's death was expected. Staff told us this was very much appreciated by families of deceased patients who had died at home, particularly during the night time.
- There was a lack of written information to give to patients and carers receiving unplanned care in the ICCTs. We saw written information given to patients in the specialist services.
- We saw some examples of patients being consulted in their future care plans and involved in their care planning. We saw this happened with patients who were at end of life and also with patients who had just accessed the service.

## Emotional support

- Staff telephoned patients the day after their procedure in the day surgery service to provide any advice or support the patient may require. Patients in this service were also able to come back to the service, in working hours, for any additional support they needed after their procedure.
- The district nurses visited the families of patients on the end of life care plan after the patient had died. They were able to signpost families to agencies for support and had information leaflets with details.
- We observed an exceptionally high standard of emotional support provided to a complex patient and family in the community rehabilitation team.

Requires improvement

# Are services responsive to people's needs?

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

## Summary

We rated responsive as requires improvement because:

- There were waiting lists or delays in some services where patients were waiting for assessment and treatment. In some of these services there were processes to manage this situation but not in others.
- We saw a patient whose first language was not English not having an interpreter arranged for them.
- Staff in the single point of contact had not been trained in dealing with patients with mental health problems.
- The service did not have systems or process to ensure learning from complaints was cascaded to staff and any changes in practice were communicated and implemented.

However:

- There had been improvements to the single point of contact response times.
- Referral to treatment times in some services were above the set target and within the 18 week referral to treatment national indicator.
- The service was working with other local statutory and voluntary organisations to improve the health and well-being of local residents and patients.
- There was evidence of good progress in becoming a dementia friendly service despite not having a dementia strategy.

## Planning and delivering services which meet people's needs

- The care home support team was made up of nursing, pharmacy and therapy staff. This team provided support to patients who lived in care homes and had been admitted to hospital. They offered advice and support to the care home staff to help limit avoidable hospital admissions. This included training to care home staff. Data shows there was a 19% reduction in hospital admissions from patients in care homes from 2015 to the time of our inspection.
- Patients on the community matrons' caseloads were high intensity patients. These were patients with at least one long-term condition, an increase in GP visits and at least one hospital admission in the past 12 months. There were patients meeting these criteria who had not been assessed as community matrons had been supporting the integrated community care teams (ICCTs) with staffing shortfalls. We reviewed data, which showed 355 patients with a known long-term condition were waiting for an annual review in September 2016. This data did not include the length of time patients had been waiting. However, we were advised by senior managers a review of this situation was underway and the data quality suggested the number of patients waiting was less than this.
- At the Princess Royal Health Centre there was a lack of clear signage to the foot health service. We were told patients had missed appointments as they had been told by staff working for a different organisation who also use the building that foot health was not run there. Managers were aware of this and it was included in the development plans for the site. We raised concerns at the time of our inspection and saw temporary signage in place when we returned on our unannounced visit.
- There was a waiting list for the respiratory service. We were told this was approximately eight weeks, which was an improvement on the waiting times earlier in 2016. To achieve this improvement, the team had implemented different ways of improving attendance such as telephoning patients prior to their appointments. The service had also set up an asthma clinic.
- Managers told us there was a waiting list for assessment in the Jubilee rehabilitation clinic of eight weeks. Staff prioritised those patients on the waiting list depending on their clinical needs. There had also been changes to working practises with more group sessions, more specific goal setting and signposting to other services such as the patient active leisure scheme (PALS).

## Equality and diversity

- Senior managers were aware of gaps and inconsistencies in the equality monitoring information collected. There were no timescales for improvements to be made in collection and analysing the data.
- Locala is required to meet the requirements of the Accessible Information Standard this year, which will ensure that the specific communication needs of service users and carers are met. Most staff we spoke with were

aware of how to access interpreting services if needed. For unplanned or urgent visits, particularly out of hours, where the patient did not understand or speak English, staff said they would use family members and arrange an interpreter for the next visit. However, we observed a district nurse not being able to communicate effectively with a patient due to language issues. An interpreter had not been arranged for this patient and a member of the inspection team provided the necessary translation, with the patient's consent.

- Equality and diversity training was mandatory and 63.2% of staff were compliant with this training against an organisation target of 100%.
- The end of life care lead had been involved in a promotional event on the local Asian radio station to raise awareness of the service.
- Appointment times in some services were arranged to improve attendances by avoiding days where religious beliefs were being observed by patients.
- Most patient information leaflets were printed in English and were not available in other languages. Managers had recognised this was an area for improvement. However, patient information leaflets for pressure ulcer prevention were available in Polish and Urdu. Staff were aware that other information leaflets were available in other languages on request. Patient information was also available via the 'Google Translate' feature of the organisation's website.
- The TB team had a bilingual support worker who assisted with language and understanding needs of patients using this service.

### Meeting the needs of people in vulnerable circumstances

- The ICCTs worked closely with Age UK and had developed a personal independence worker role. Two workers supported isolated patients who had reoccurring hospital attendances and lacked family support. From May to August 2016, these workers had supported 86 socially isolated patients assisting them in navigating the health and social care system.
- A number of specialist services were able to refer patients to a scheme run in partnership with the local authority called patient active leisure scheme (PALS), where patients could access activities, providing an opportunity for exercise at a subsidised rate.
- The service had also developed a pilot scheme with a housing association to address the health and well-being needs of people living in this setting and reduce the demand on health and social care services. A housing officer was now part of an ICCT.
- The organisation told us they did not have a dementia strategy. However, they had received an award in 2015 in recognition from a local voluntary group specialising in dementia care of the work to become dementia friendly. Dementia awareness training was mandatory. Information supplied to us showed 83.5% of staff had received this training up to March 2016 against a target of 100%. Another 90 members of staff had undertaken dementia friends training.
- The organisation did not have a learning disability strategy.
- The service worked with a charity providing IT training with older people. This had helped older people engage with others via social media and learn to look after themselves by accessing information on the internet.
- The continence service and the specialist diabetes and cardiac rehabilitation services monitored the did not attend (DNA) rates. Information supplied showed the patient contact DNA rates varied between 3.36% and 0.14% with the average being 1.06% between 1 March 2016 and 31 August 2016. The patient appointment DNA rates for the specialist diabetes service had improved during this period from 14.38% in March 2016 to 4.58% in August 2016.
- The diabetes nurse specialists visited patients at home if they were unable to attend a clinic. They also had outreach into GP surgeries, care homes and antenatal clinics at the acute hospitals. There was a young adults' clinic and the team also worked with the paediatric diabetes service to ensure young people were introduced to adult services at the point of transition. The single point of contact (SPOC) had taken referrals for the over 65 years mental health services from August 2016. Call handlers had five screening questions to ask before transferring the call to the mental health team. Staff told us they had not received mental health training for this work.
- There was no Parkinson's disease nurse specialist in the north of the locality and we did not see any plans to appoint one.

Requires improvement

# Are services responsive to people's needs?

## Access to the right care at the right time

- The single point of contact (SPOC) was a new service in the organisation, introduced in February 2016. It was the first point of contact for all patients using adult services. The service was co-located with the local authority adult social care contact point.
- The SPOC was set up when the care closer to home contract was implemented and operated a 24-hour service. The service did not have sufficient capacity to deal with demand initially.
- The SPOC received on average 12,000 calls per month. We saw from performance information that there had been a significant improvement in the call answering times, from 12% of calls being answered in 90 seconds in February 2016 to over 80% being answered within 90 seconds in May 2016. The performance target was 80%. Performance information also showed callers waiting up to 60 minutes for their call to be answered in February 2016. In May 2016, the longest time a caller was waiting was 15 minutes.
- There had been a number of complaints received about the service early in 2016, due to the amount of time callers were waiting to be answered. Action had been taken to address these problems with additional desk space being secured and staffing levels increased from 22 whole time equivalent (WTE) to 33 WTE. There were still six vacancies at the time of our inspection.
- The call handlers worked flexibly and there were more staff working at peak times, such as Monday morning and Friday afternoon.
- Palliative care patients and their families were given a different number to contact the SPOC. The appropriate call handlers recognised this and the calls were prioritised for answering.
- There were clinicians based in the SPOC who provided advice to call handlers from 7am to 11pm and spoke with patients or carers if required. If advice was required outside this time, the clinical lead in the out of hour's integrated nursing team was able to provide this.
- A clear process was in place for call handlers to escalate calls or ask for advice from the clinicians. Most clinicians were district nurses. There were contact numbers for a link in each of the specialist teams between 9am and 5pm Monday to Friday. All calls to the SPOC were recorded and audited. The time call handlers spent on each call was also monitored.
- There were clear algorithms on screen for call handlers to follow to ensure that patients were referred to the correct service in a timely manner. These algorithms gave staff the information they required to prioritise the call into the response times of either, zero – 2 hours, 2 – 24 hours, up to 3 days and more than 3 days.
- Performance information for the period April 2016 to September 2016 for patients seen between 0-2 hours in the ICCTs was 84.7%. This was an improving picture with 76.5% of patients seen in April 2016 and 94% of patients seen in September 2016. However, this meant 30 patients were not seen in the 0-2 hours timeframe. Most of these patients (26) were seen within the next two hours but one patient was not seen and the reason had not been recorded.
- Performance information in September 2016 showed that 94.8% of patients requiring a 2 – 24 hour visit from referral were seen within the timeframe. For the same month, 98.7% of patients needing to be seen within three days of referral were seen.
- The number of inappropriate referrals was not audited. For example, the number of calls for unplanned care which were referred to district nursing which should have been referred to adult social care.
- Following the service review of complaints about the SPOC service the related action plan included looking at signposting callers to the voluntary sector.
- There were no waiting lists in some teams. For example, the cardiology team were able to see patients within seven days of referral and had developed criteria for urgent patients, who were seen within three days.
- Managers told us they were aware of patients' assessments not being completed which they thought was having an impact on patient care and treatment, care pathways and delayed discharge from the service. At the time of our inspection, details of the impact of this were not available.
- Nursing staff told us that patients were receiving their morning insulin unacceptably late. Staff told us some nurses had up to four pre-breakfast insulin administration visits to do.
- In podiatry, there were almost 500 patients on the list waiting to be seen at the time of our inspection. In order to manage this, all patients had been sent a letter requesting they contacted the service to opt in and make an appointment. If patients had not replied within three weeks they had been removed from the waiting list. The maximum waiting time was 18 weeks. The

service had a triage system in place for patients waiting for appointments. This started in the SPOC where diabetic patients were prioritised and seen within 24 hours of referral. All patient referrals were passed to the podiatry teams and triaged by a clinician. At the time of our inspection there were more than 170 non-urgent referrals waiting to be triaged by a clinician.

- Further information supplied by the provider after our inspection showed that there were 625 podiatry patients waiting to be seen on 23 December 2016. However, none of these had been waiting more than the national indicator of 18 weeks and there were no urgent referrals waiting. There were also 162 non-urgent referrals awaiting triage. Managers told us there were plans for an additional clinic to be held in January 2017 to improve the waiting times.
- Urgent referrals out of hours were taken by call handlers at the SPOC and passed electronically to the team leader in the out of hour's integrated nursing team.
- Performance data showed the day surgery service achieved the key performance indicator (KPI) of 95.2% to 100% of patients being treated within the national target of 18 weeks from referral. In this service, patients attended a preoperative assessment within six weeks of the scheduled date for surgery. Patients were given a choice of when they would like their procedure to take place.
- Patients who attended the diabetes clinics were given an email address so they could contact members of the team for advice. The specialist nurses would respond by telephone or email. Patients could also ask to speak to the nurses in the diabetes clinic by calling the SPOC.
- We were told and saw in the integrated adults' business unit meeting minutes that the flu vaccination programme for autumn 2016 had been delayed due to the lack of staff in the planned ICCTs. The organisation had an agreement with the local clinical commissioning groups regarding delivery of the flu vaccination campaign in the localities.There was a shortage of ear irrigation kits. This had resulted in delays in patients receiving care and treatment. A new kit was on order at the time of our inspection.
- There was a waiting list of 355 patients awaiting an annual long-term conditions review at the time of inspection. This was due short staffing in the ICCTs and community matrons being requested to undertake district nursing tasks to support the ICCTs. Senior managers told us this number may not be accurate as further validation was being undertaken.
- We read in meeting minutes that patients with lower limb wounds requiring Doppler tests were not receiving these in a timely way due to the shortage of nursing staff with the skills and knowledge to undertake this. There was also some confusion as to which commissioned service was responsible for this.
- Day surgery patients were advised to call the SPOC if they had any problems out of hours. The staff in the SPOC had a flow chart to assist them with the advice to give to these patients.
- The use of technology such as Skype and photographs allowed the correct professional to see, assess, refer to specialists and prescribe the correct treatment in one visit or contact.
- There were clear criteria for acceptance onto the caseload of the intravenous home support team. Referrals came from the acute hospitals via the SPOC.
- The respiratory service informed us there were difficulties in obtaining some specific medications for patients due to funding responsibility disagreements with commissioners. We saw in the business unit minutes there were plans to discuss this further with the commissioners.
- Some services were able to accommodate a drop-in clinic service such as the diabetes specialist service. This service was also able to conduct telephone consultations.
- We saw patients being offered a range of dates and times for appointments in specialist services, so patients were given a choice of a time that suited them.
- District nurses in the planned team were not able to offer patients timed visits, which meant patients were waiting for the nurse to arrive all day, into the evening and in some cases overnight. Staff told us until there were more staff in the teams it would not be possible to offer timed visits.
- Scheduled visits were sometimes deferred because of staffing shortages. A manager in one ICCT told us some routine daily dressing changes may be delayed or passed onto the next day as part of staff prioritising what could be done with the resources available. This manager told us this situation would not be reported as an incident.

Requires improvement

# Are services responsive to people's needs?

- There was no formal guidance for staff regarding assessing risk and recording on the system when a scheduled visit had to be deferred. Patients were contacted by telephone and informed if a visit was to be missed. Visits were rescheduled but the system would not show if a visit had previously been deferred.
- There was not a robust system for identifying patients whose visits had been deferred and assessing the risk to patients who had missed visits. At the time of our inspection there was also no recovery plan to catch up with this backlog of routine or non-urgent work.
- We were told about a patient who had been transferred to the local hospice out of hours, as this was their preferred place of death. This had been facilitated by the out of hours' integrated service.

## Learning from complaints and concerns

- We saw leaflets for patients and carers in a number of the locations we visited advising how to make a complaint. Some staff told us they carried contact cards for patients who wanted to complain. Staff said they encouraged patients and families to speak up if they had a complaint about the service.
- The integrated adults business unit had received 85 complaints between 1 July 2015 and 12 July 2016. Most of these (34) related to the ICCTs. The main reason for these complaints (16) was described as clinical treatment, with staff attitude and behaviour attributed to seven complaints and oral communication to four complaints. The podiatry service received 22 complaints with the main cause of these being appointments (8) and oral communication (5).
- There had been learning from patient complaints about the lack of signage at Princess Royal Health Centre and a map of the premises was now printed on the back of appointment letters.
- The service had customer engagement managers in post who were responsible for responding to complaints.
- There was some evidence of learning from complaints. For example, complaints relating to the waiting time in the continence service had resulted in letters being sent to waiting patients with an explanation. However, there was no formal assurance process in place to check actions and learning had taken place after a complaint investigation. Senior managers were aware of this gap in assurance. However, there was no timescale to address this and this was not mentioned in the integrated adults' business unit key opportunities, risks and successes document.
- A complaints closure panel met on a quarterly basis and any themes for this were communicated to staff in a newsletter via email. Staff told us they did not always have time to read emails.
- The service had a portal on their website called 'patient opinion' where patients or their family were able to leave comments. The service had made changes as a result of complaints and comments received, for example, recruiting more call handlers to the SPOC.

Inadequate

# Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Summary

We rated well led as inadequate because:

- Many staff we spoke with said they did not feel supported by their managers. There was evidence of a disconnection between senior managers and the front line staff.
- The ability of the organisation to develop staff and improve services in the integrated community care teams (ICCTs) was very limited by staffing shortages.
- Overall governance processes were weak. There was a lack of risk management strategies. There was poor oversight of risk and mitigation.
- The service did not fully understand the needs of the population it served, therefore planning services and having teams that were able to competently meet the capacity and demand were not in place. This had been recognised by the senior management team and a scoping exercise was cited as an action on the recovery plan for the ICCTs.
- Staff were not provided with up to date guidance or consistent systems to keep themselves safe at work.
- Many staff told us here had been little engagement with staff at a time of great change in the services. This had resulted in unclear pathways, lack of policies to support staff and a poor transition into new ways of working.
- The situation of backlogs in patient visits and assessments did not have a robust recovery plan. There was a lack of oversight and risk assessment for this.
- There was no robust risk register, so the service lacked oversight and management of the risks and did not have robust plans in place to address the risks.

However:

- The chief executive did invite staff to contact him directly and staff told us they had done so.
- Some staff said they were happy to work for an organisation with a 'can do' culture portrayed by the senior managers.
- Patient survey results were positive and there had been good engagement and innovation with local voluntary sector providers to meet the needs of lonely older people.

## Leadership of the service

- Senior managers told us they were implementing a process called "shifting the focus" to enhance the organisation's vision and strategy. To achieve this, senior managers said they were making conscious efforts to be more visible. Some staff we spoke with did not reflect this enhanced visibility and said senior managers were not visible.
- District nurses told us about a lack of support from managers and some told us they had received an apology from senior managers when they had raised this. A new appointment had been made to the board of directors to lead the transformation of operational services. A medical advisor had also been recruited to the board to provide medical leadership.
- The integrated community care team (ICCT) managers had monthly peer support meetings. Some ICCT managers were relatively new in post at the time of our inspection.
- Senior managers told us that there was investment in leadership development for operational staff. Some staff we spoke with were aware of this but reported they had experienced difficulties in being released to attend any courses. Information supplied showed that in 2016, three members of nursing staff had attended a restorative supervision course and twenty four members of staff had attended an in house leadership course between October 2015 and October 2016.
- Some staff in the ICCTs told us that a senior manager had attended a team meeting when invited. However, they did not feel actions were taken as a result of listening to their concerns.
- As part of the action plan to address the low compliance rate of appraisals in the ICCTs, this was to be a standing item on the operational group meetings. We reviewed the ICCT meetings agendas and minutes and found this was the case but there was little progress noted.
- Staff in the specialist teams told us their immediate line management was good. They felt valued and involved with service developments.

Inadequate

# Are services well-led?

## Service vision and strategy

- The organisation had a vision and strategy. Staff were able to tell us of the organisation's values of "Be caring. Be inspirational. Be part of it", but some staff described these as "just words".
- The vision and strategy for the integrated adults business unit was the model of care set out in the care closer to home contract. Many staff in the ICCTs were not able to articulate what the vision and strategy were. Following the inspection senior managers told us the vision and strategy of the care closer to home model had been communicated to staff via a series of roadshows. However, staff did not tell us about these.
- Senior managers acknowledged in meeting minutes where the ICCT recovery plan was discussed that a review of the needs of the local population was required to ensure the implications of the care closer to home contract were fully understood. There was recognition of the additional demands being made on services. We saw the organisation's vision and values on display in a number of the locations we visited.

## Governance, risk management and quality measurement

- Senior managers were aware that the organisation's governance structures required improvement and action had recently been taken to improve this. However, staff confirmed to us that the current system did not inform them of detailed clinical performance of the service or particular areas where performance required improvement. Our review of the data and documents supplied by the service demonstrated this to be the case.
- There was a document known as key opportunities, risks and successes or KORS. Senior managers told us KORS had been used since 2014.The service managers used the KORS template to document opportunities, successes and risks in their areas. This was updated on a monthly basis. However, the KORS documents were not sufficient for the robust management of risk within the service.
- Managers in the ICCTs told us that the KORS had been changed recently and they had not received any specific training on what it should contain. Senior managers told us the template had been revised but the content of KORS had remained the same.
- We reviewed the KORS for three ICCT localities and saw there was no area for recording the mitigation of any risks identified. This was also the case on the integrated adults business unit KORS. Therefore, there was a risk that senior managers had little oversight or knowledge of what was being done in the localities to mitigate the identified risks.
- The KORS document showed a risk scoring process using an impact and likelihood methodology. However, the highest scoring risks were not at the top of the document, which was shared with the integrated adults' business assurance group and the senior managers. This meant that the highest risks were not easily identifiable.
- The most recent KORS document dated September 2016, referred to risks associated with the REAP levels regarding staff shortages in the ICCTs. However, it did not identify the waiting lists of non-urgent patients as a risk and there were no action plans setting out how the service intended to recover the position.
- We reviewed the business assurance map and strategic risks and associate corporate risks documents for August 2016. There were no actions identified in these regarding the assessment and management of the risks associated with deferring patient contacts in the ICCTs. We were not assured there was an effective system in place to monitor the number and type of non-urgent patients whose visits had been deferred as part of the ongoing REAP response to reduced staffing levels. We were also not assured there was an effective system in place to monitor the number of patients on waiting lists which had formed as a result of deferred visits.
- The REAP levels in the ICCTs had been consistently above level 3 since August 2016 as a result of staff shortages. One of the actions in this situation was to prioritise patient visits. Staff at various levels, including senior managers were not able to articulate the volume of patients whose visits had been deferred as part of the REAP response.
- There were no risk escalation criteria in place at the time of our inspection.
- The action plan following the serious incident involving the administration of insulin included dates for actions to be completed but we did not see evidence offurther monitoring by operational managers or the medicines management committee to ensure the recommendations had been fully implemented in practice. An audit was conducted in October 2016 which

showed an initial reduction in insulin administration errors after the serious incident with four errors in May, two in June and July, one in August but four in September. This meant senior managers could not be assured the risk of reoccurrence had been minimised and sustained.

- Risks identified through audit were not always linked to robust action plans. For example, the need for more than one anaphylaxis kit at Princess Royal Health Centre recommended in March 2014, had not been addressed and no further audits had been scheduled after this date. This meant senior managers were not always assured that identified risks were reduced.
- We reviewed the ICCT recovery plan dated July 2016 which was developed in response to the concerns raised by staff about capacity and meeting the demands of the service. The recovery plan did not contain any detailed analysis of the issues raised or their impact. A further version of the recovery plan dated October 2016 was submitted to us during our inspection. We reviewed this and found some actions had been updated. Staff and managers in the ICCTs did not refer to actions contained in the recovery plan except for plan for recruitment.
- We reviewed minutes of the Scrutiny Management Group and the Finance Performance and Quality Committee. They showed that the staffing issues in the ICCTs had been escalated and a number of actions had been agreed to address them.
- We raised concerns about the ICCT recovery plan at the time of our inspection. Locala subsequently provided information and an additional action plan that was in place at the time of inspection but this was not a comprehensive plan. It did not contain a robust plan to address the staffing shortfalls and seemed to focus on resolving IT issues. Senior managers told us resolving IT issues was the priority identified by the ICCTs during a series of team meetings in August and September 2016.
- The lack of understanding of the needs of the population was to be addressed by a review of public health data in order to understand the demand on each locality. This was identified in the recovery plan and was completed in June 2016.
- A serious incident in the service in July 2016 highlighted a new member of staff had not been properly supervised or had their competencies checked. The organisation had a guide for managers relating to new starters but this had not been followed. This serious incident also highlighted poor human resources systems, as pre-employment checks had not been carried out prior to a member of staff starting work with the organisation.
- Senior managers told us there was a new way of conducting business unit meetings being introduced. From August 2016 monthly meetings were held for three groups: Clinical Quality and Patient Safety, Finance and Performance and Assurance. The terms of reference for these groups were being finalised at the time of the inspection. However, these changes were so recent that it was too early for the team and inspectors to assess the impact.
- There was a framework in place for meetings. Monthly operational meetings were held. However, there were few opportunities for staff in the ICCTs to attend team meetings due to the workload.

### Culture within this service

- We found a mixed picture in relation to culture within the service.
- There was a culture of 'being different' in the delivery of services. Some staff were proud of this alternative approach.
- Some staff said they were very happy to be working in an organisation which allowed them the freedom to develop ideas and do things to improve the patient experience. An example of this was given in the continence service.
- Some staff said they felt supported by the senior management team. However, others said they did not feel supported. They said senior managers did not understand their roles and the pressure they were currently experiencing. They did not feel they could raise concerns or did not feel they were listened to.
- Some staff said there was a no blame culture in the organisation when things went wrong and they felt supported by this. However, one member of staff told us their manager had not been supportive and indicated it was their fault they could not cope with the workload and responsibilities.
- Staff told us that in some teams there was a flexible approach to working hours in order for a positive work/life balance to be achieved. This was reflected in the integrated adults business unit staff survey result in June 2016 where some staff had commented on the benefits of flexible working.

Inadequate

# Are services well-led?

## Lone Working

- The organisation had a lone working procedure for staff. However, this should have been reviewed in October 2015. Staff who worked alone did not have an up to date policy or standard operating procedure to refer to. We found different teams had set up their own ways of ensuring that staff were safe. Some staff said they had bought their own personal alarms. Staff were using social media, electronic messaging services and coded conversations if in the home of a patient. However, this system did not always work and we were informed of a situation where a member of staff was lone working to 6pm at a weekend and the team leader not being aware of this.
- Staff were aware of a panic alarm on their laptops. However, this would not work if the laptop had lost connectivity. Managers were looking into trialling a key fob type alarm for staff to use. This was recorded on the KORS. However, there was no plan or timescale given for improving staff safety.
- Staff told us they felt anxious about some visits after dark and visiting some areas during the daytime by themselves. They had raised concerns with senior managers who were exploring different lone working safety devices.
- There was no lone working from 10pm. The out of hour's integrated team always worked in pairs.
- There had been an instance of a laptop being stolen from a staff member's car. We noted staff did not store their laptops in bags and carried them in an open position making them more vulnerable. Staff in some ICCTs did not know about the laptop theft.
- Conflict resolution training was mandatory and 47.6% of staff were compliant with this training against an organisation target of 100%.

## Public engagement

- The service was planning changes to the provision of podiatry in Huddersfield. Senior managers told us there would be public engagement and consultation in relation to this.
- The organisation was working with local voluntary groups to support vulnerable people in the community. An example of this was the work with Age UK to provide a support worker to those without any close family.
- All business units had a customer engagement manager.
- Friends and family test results from June 2016 showed 95% of patients said they would be likely or very likely to recommend the organisation to their family or friends. Patient survey results demonstrated a positive outcome in 98% of cases in August 2016.
- There had been two posts on the patient opinion website indicating a lack of communication regarding the restructuring of the district nursing services. The service subsequently sent personal letters about the change to all community nursing patients.

## Staff engagement

- Staff in the ICCTs did not feel engaged with the senior managers of the service. Many staff told us they did not think the senior management understood what they and their teams did. Some staff working in the ICCTs did not think that the senior management team were listening to them and responding to their concerns.
- Senior managers had attended some teams meetings in the specialist services and ICCTs during 2015 and early 2016 when the care closer to home contract was implemented. Senior managers also told us a series of roadshows and engagement events for staff had been held before the care closer to home contract was awarded and implemented. We did not see evidence showing the attendance of staff at these events.
- In the specialist services teams, staff were more positive with comments such as "I feel involved", "we are given freedom to pursue our own ideas" and "we feel empowered".
- Senior managers told us the amount of change in implementing the care closer to home contract had caused fatigue and apathy amongst staff in the ICCTs. We saw this in some teams we visited and staff told us that this was the case. There were some plans to improve this on the ICCT recovery plan but no timescales.
- All staff we spoke with received weekly electronic newsletters via email. Some staff said they did not have time to read these, or did so in their own time.
- Staff we spoke with said they had been offered training opportunities and support but felt disillusioned and let down as it had not happened. However, some staff in the specialist services had accessed additional training to help them in their role.
- Senior managers had recognised there were issues with staff morale within the service. One of the actions taken to improve morale was to create a team fund and a

wellbeing fund for staff. Teams could apply for these funds to pay for team activities of their choice to provide alternative ways of team building or improve the working environment for staff. Some teams had used this in the last 12 months.

- The integrated adults business unit (IABU) staff survey results from June 2016 showed 73% of staff (of the 161 respondents) would recommend the organisation as a place to receive care and treatment. This is above the score in the NHS staff survey where 69% recommended the organisation they work for as a place to receive care and treatment.
- Some staff told us they did not feel confident to speak up about their concerns about the service. However, the IABU staff survey results from June 2016 showed 79% of staff (out of the 506 respondents) indicated they felt secure in raising concerns. This compared to 68% of staff in the NHS staff survey.
- The staff survey results from June 2016 showed 29% of the respondents thought communication with staff was not effective and 39% thought communication with staff was effective. The same survey also indicated that 20.5% of respondents did not agree that the organisation's top priority was care of patients.
- Staff in the ICCTs said they lacked opportunities for peer support due to the volume of work and not being able to return to a base for a lunch break. The IABU staff survey results in June 2016 showed 26.2% of respondents indicating they felt isolated at work.
- Managers informed us staff involved in the serious safeguarding incident had been invited to attend a session arranged with an independent counsellor. However, staff told us they had not been able to attend as there were insufficient staff available due to other commitments. Senior managers informed us ten members had attended a group supervision session related to this incident and a follow up session had been arranged for staff who were unable to attend.
- The organisation had facilitated stress workshops for staff but had noted in the IABU meeting minutes that the staff who were in need of support had not attended.
- The chief executive invited staff to email him directly. Some staff we spoke with said they had done this and there had been a response and actions. For example, the provision of a fax machine in a specialist team.
- Most staff we spoke with were not aware of the organisation's whistleblowing policy and did not know about the recently appointed freedom to speak up guardian. However, we did see results of a survey undertaken in May 2015 which showed 82% of staff were aware of the whistle blowing policy at that time.
- Some staff were aware of the "health check" which had been offered to staff to provide advice and support through occupational health.
- There was a staff suggestion box in the single point of contact (SPOC).

### Innovation, improvement and sustainability

- Projects involving local charities and housing associations had a positive impact on patients. For example, the service had engaged with a voluntary organisation to educate older people to use technology to assist in virtual consultations in the future as well as remove social isolation.
- The Jubilee rehabilitation team were producing a patient education DVD and using music to assist patients with Parkinson's disease.
- The SPOC were piloting virtual contacts in five care homes using Skype with the patient's consent for the clinicians to determine if an urgent district nursing visit was required.
- The palliative care team had won an award at a national level for innovation.
- The use of technology such as Skype and photographs allowed the correct professional to see, assess, refer to specialists and prescribe the correct treatment in one visit or contact.

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 |
|---|---|
| Nursing care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 (2) (b) Doing all that is reasonably practicable to mitigate any such risks<br><br>How the regulation was not being met<br><br>· An incident was not identified as a serious for five months.<br><br>· There was a backlog of incidents awaiting completion of investigation.<br><br>· A serious incident had been incorrectly determined as unavoidable.<br><br>Regulation 12 (2) (c) Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely<br><br>How the regulation was not being met<br><br>·There were some staff in the integrated community care teams who were noted in meeting minutes as not meeting competency requirements.<br><br>Regulation 12 (2) (h) Assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated |

This section is primarily information for the provider

# Requirement notices

How the regulation was not being met

· Four infection prevention and control policies were out of date.

·The infection prevention and control (IPC) audit timetable hadn't been followed in all the services that we inspected. There were high levels of non-submission of IPC audit data in some of the business units, particularly the integrated adults business unit.

·Some equipment was not in-line with IPC best practice at the Princess Royal Health Centre. At Princess Royal Health Centre sterile equipment was not stored appropriately and there was no hand gel available for patients.

| Regulated activity | Regulation |
| --- | --- |
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Regulation 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.<br><br>How the regulation was not being met<br>·The processes for identifying and reviewing serious incident investigations were not robust.<br>·There was no systematic approach to reporting incidents to the Board.<br>·Action plans were not always comprehensive and their implementation was not always robustly monitored.<br>Regulation 17 (2) (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity<br><br>How the regulation was not being met |

This section is primarily information for the provider

# Requirement notices

·Risks were not appropriately escalated and managed within the organisation, for example the impact of acute staffing shortfalls within the integrated community care teams.

·Risk management tools were not robust.

·There were not always robust and comprehensive action plans in place to mitigate risks.

·Audit programmes were not always followed and outcomes were not consistently reported through the governance structure.

| Regulated activity | Regulation |
| --- | --- |
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Regulation 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part<br><br>How the regulation was not being met<br>·There were significant staffing shortfalls in the integrated community care teams.<br><br>Regulation 18 (2) Persons employed by the provider in the provision of a regulated activity must -<br><br>Regulation 18 (2) (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform<br><br>How the regulation was not being met<br>· Mandatory training compliance rates were significantly below target in some of the services that we inspected.<br>·Staff did not receive individual clinical supervision in the community adults service. |

This section is primarily information for the provider

# Requirement notices

·Compliance rates for safeguarding children training were low in the community adults service.

·Appraisal rates were low in the community adults service.

| Regulated activity | Regulation |
| --- | --- |
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 20 HSCA (RA) Regulations 2014 Duty of candour<br>**Regulation 20(1)** Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity<br><br>How the regulation was not being met<br><br>Compliance with the duty of candour requirements was not embedded across the organisation. We saw examples of the duty of candour not being implemented as soon as reasonably practicable and where the application of the duty of candour was appropriate and had not been applied, such as for category four pressure ulcers. |