Leeds Community Healthcare NHS Trust

RY6

Community health services for adults

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Leeds Community Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Leeds Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Leeds Community Healthcare NHS Trust

Summary of findings

Ratings

Overall rating for Community health services for adults	Good
Are Community health services for adults safe?	Requires Improvement
Are Community health services for adults effective?	Good
Are Community health services for adults caring?	Good
Are Community health services for adults responsive?	Good
Are Community health services for adults well-led?	Good

Summary of findings

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Summary of findings

Overall summary

There was a system in place to report incidents however we saw learning from incidents was variable.

Staff were competent to carry out their role, identified and responded to patient risk that ensured patient safety. There were vacancies across the service, which meant caseloads were high for some nursing and therapy teams. Managers and staff within the district nursing service did express concern regarding staffing levels and these had been on-going for some time. Some staff told us they felt under pressure due to staff shortages.

A range of audits had taken place however some services had limited audit activity in relation to the outcome and impact of the services they provided.

The service was caring; care and treatment was evidence based and staff followed current best practice recommendations. There were positive examples of multidisciplinary working across internal services and between local healthcare organisations. All patients and carers spoke positively about the care provided and we observed staff deliver compassionate care.

The service was responsive to patient need and patients were treated in their own homes or community clinics where possible. Services engaged with patients to gain feedback and improve services.

There were notable examples of innovation.

Summary of findings

Background to the service

Leeds Community Healthcare NHS Trust delivered community based services to adults with long term conditions across Leeds. The area included a large urban conurbation with levels of deprivation as well as pockets of relative affluence. The service provided a range of health services including district nursing, integrated care and therapy.

The service worked with patients, across trust services and other local healthcare, third sector and social care organisations. Care was delivered in a range of locations, including patients' own homes, and community based health clinics.

During our inspection, we visited district nurses, community matrons, intermediate care, musculoskeletal (MSK), improving access to psychological therapies (IAPT), healthy lifestyles, the stop smoking service, weight management services, continence, diabetes services, cardiac services, and podiatry services based at health centres in all areas of Leeds. During the inspection we held focus groups with a range of staff who worked within the service, including nurses, therapists and healthcare assistants We spoke with 87 members of staff working within these teams. We spoke with staff, including nurses, managers, therapists, support staff, and administrative staff.

We observed care and treatment during 14 visits and appointments; we spoke with 29 patients and relatives and looked at 16 care records. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

Our inspection team

Our inspection team was led by:

Chair: Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; school nurse, health visitor, GP, nurses, therapists, senior managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Leeds Community Healthcare NHS Trust was inspected as part of CQC's inspection programme. The trust is also seeking to become a foundation trust. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.

Summary of findings

2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services

Before visiting, we reviewed a range of information we hold about Leeds Community Healthcare NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 24 and 27 November 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 29 locations which included 3 community inpatient facilities. We carried out unannounced visits on 26 November to the twilight service and child development services.

What people who use the provider say

Patients told us they felt safe using the services provided by the trust in the community and at clinics. They told us that staff were friendly, went out of their way to help their patients and seemed happy in their work.

Patients felt listened to by trust staff, respected and involved in their care planning and treatment. They commented positively on the attitude of staff and their competence and professionalism.

Patients reported good access to pain relief.

Good practice

- Staff from the Leeds continence, urology and colorectal service had produced of a video to launch the new national bowel care guidelines.
- The community nursing service had implemented an adult integration programme - A model for integrated health and social care for adults in Leeds. Social workers were aligned and work within the neighbourhood teams to provide a more person centred service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should review staffing levels in community teams to ensure they are safe, especially at times of high vacancies.
- The trust should review how it collects and reports patient outcomes in community services.
- The trust should ensure that there are processes in place to allow staff to transcribe medicines safely

Leeds Community Healthcare NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

Summary

Staffing levels in some services required improvement. The trust were aware of this and had plans in place to address this. However, this was impacting on staff morale.

The services had well established systems for incident reporting and analysis using the Datix reporting system. Staff told us and we saw evidence in team meeting notes that incidents were analysed at a local level and learning was discussed within teams. Staff understood their responsibilities to raise concerns, and report incidents and near misses.

The majority of medicines management practices were good; however we identified concerns regarding the transcription of medicines.

There were effective arrangements in place to manage and monitor the prevention and control of infection, and safeguarding people from abuse.

Detailed Findings

Incident reporting, learning and improvement

Incidents were reported using the electronic DATIX system. Staff told us that they were encouraged to complete incident reports. A recent review of capacity and demand completed by the trust identified the way the Datix system was used was time consuming for the district nurses and there was evidence of under-reporting within district nursing services due to the time it took to complete incident reports, and a lack of access to computers for staff to complete the reports. However it was noted that the trust had plans in place for the introduction of tablet computers for district nursing staff and the development of electronic patient records through 2015-2016.

Between 18th September 2013 and 17th September 2014 there were 26 serious incidents reported on STEIS which included 14 pressure ulcers grade 3 & 4 reported for patients receiving care in their own home and 3 pressure ulcer incidents in a residential care setting. Five incidents were recorded as the development or deterioration of a pressure ulcer to category 2.

Requires Improvement

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There was one serious incident where a patient previously under the care of the trusts district nurses and community matrons was admitted to hospital and diagnosed with MRSA and subsequently died. The infection was identified as being community acquired.

There were 680 relating medication incidents with 11 of these causing moderate harm. 482 incidents relating to implementation of care and ongoing monitoring /review were reported with 143 of these resulting in moderate harm. There were 172 incidents relating to treatment, procedure with 3 resulting in severe harm and 54 resulting in moderate harm. This showed that there was a strong culture of reporting safety incident in adult services. However at one stage adult services had 329 incidents which still needed the incident investigations to be completed. The trust had put in place additional resources to reduce this figure down to 86 incidents. The trust should continue to improve post incident investigations; otherwise there is a risk that lessons learned from incidents would not be shared with teams in a timely and effective manner.

Learning from incidents and safety alerts was shared at team meetings. We saw meeting minutes that supported this. There was also a folder in the office which contained alerts. Staff were told to read and sign that they had read the alerts. We reviewed 2 alerts and found that only four and six out of 21 staff had signed to say they had read the alerts.

Staff gave examples of serious incidents that had occurred and the learning from these. Staff reported that feedback on minor issues was not always shared. For example we found all staff were aware and had received feedback from a serious incident where a patient previously under the care of the trusts district nurses and community matrons was admitted to hospital and diagnosed with MRSA and subsequently died.

The falls team we spoke with identified an incident when the service was completing a mobility check with a patient who collapsed and needed CPR. The follow up actions reinforced the need for staff to attend annual mandatory CPR training and to carry resus masks

The forecast risk for CQUIN achievement for the Safety Thermometer improvement goal was amber based on the challenging national target for health economy wide pressure ulcer reduction. This risk was being mitigated by partnership working and proactive risk reduction as part of the city wide pressure ulcer reduction plan.

We looked at the Integrated Performance Report – August 2014 and the following themes were identified. Rates of UTI's requiring a catheter had been low with no more than five cases being reported in any month reviewed. Fewer cases had been reported in the last six months compared to the first six months in the period under review (9 compared to 16).

Safety thermometer (The National Safety Thermometer is a national prevalence audit which allows us to establish a baseline against which organisations can track improvement.) results for new pressure ulcers indicated that prevalence rates had fluctuated throughout the last 12 months and had recently increased in September 2014. The increase in incidence of pressure ulcers had also been identified by Leeds South and East Clinical Commissioning Group.

Since April 2014 the trust had reported all category 3 and 4 pressure ulcers as serious incidents. A review of these had been requested by Leeds South and East CCG in September 2014.The CCG had noted a rise in prevalence on the Patient Safety Thermometer. The services had developed an action plan to improve the identification and reporting of pressure ulcer incidents. Training in the identification of pressure ulcers had been provided for community staff. Staff told us they had completed pressure ulcer training and this had led to an increase in the reporting of incidents.

Duty of Candour

The duty of candour was defined in Robert Francis' public inquiry report as: "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information had been requested and whether or not a complaint or a report about that provision had been made."

Senior managers were aware of the duty of candour. None of the clinical staff we spoke with were aware of the duty. However clinical staff were familiar with the principles of

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'being open' (National Patient Safety Agency 2009) that acknowledged, apologised, investigated and explained when things go wrong. Senior managers told us training for all staff was planned for December 2014.

We found the trust had completed a serious incident root cause analysis for the MRSA incident which resulted in a patient death. The organisation had shared learning and followed the duty of candour procedure of providing an explanation, apology, discussion and action taken as a result of this serious incident with the relatives of the patient.

Safeguarding

The trust had in place policies and procedures to safeguard vulnerable adults. A trust-wide team was available to support staff with any concerns.

All staff we spoke with were aware of their responsibility to report any safeguarding concerns that they had. All staff that we spoke with told us they felt confident about reporting any concern about the welfare of a patient.

Nursing staff gave examples of how they had made alerts to the local authority when they had concerns regarding family members' ability to care for their relatives. Continence staff had also needed to raise alerts where patients had not been given treatments as prescribed and had needed to consider mental capacity and best interests when patients declined interventions.

87% of clinical staff had completed safeguarding adults training. The service had plans to increase adult safeguarding compliance to 98% by December 2014.

Medicines management

We looked at 2 medication administration charts that showed that medicines had been transcribed by nursing staff.

We spoke with 3 band 5 nurses at one location who confirmed they routinely transcribed prescribed medication. They had not received guidance or additional training. Managerial staff we spoke with were unaware of any guidance in relation to transcribing. The Nursing and Midwifery Council guidance on medicines management specifies that whilst registered nurses can transcribe, this should only be undertaken in exceptional circumstances and employers are responsible for ensuring there is a rigorous policy for transcribing that meet local clinical governance requirements. Medicines that were transcribed and/or prescribed had been administered.

Health care assistants in the community had been trained to give insulin and tinzaparin which was competency based. Competencies of staff were reviewed by qualified staff. The training had been developed in partnership with the local university. This allowed professional development opportunities for support staff. Support workers were also suitability trained to complete tasks.

Stores of drugs and solutions were safely locked away and in date. There was a clear process for receiving, storage and disposal of drugs which was reviewed annually.

Safety of equipment

Staff reported that equipment was readily available and they received training when new or patient specific equipment was used.

Podiatry instruments were decontaminated off-site; and whilst there was no maintenance contract in place, the service would send any faulty equipment to the manufacturer for repair if required.

Podiatry clinics had secure lockable storage/ fridges for local anaesthetic, wound dressings and antiseptic solutions used during procedures such as debridement of wounds.

The community falls service used blood pressure machines which were delivered from central stores (Leeds Equipment Services). A 'clean' van was used for the delivery of equipment and a 'dirty' van for the collection of used equipment. Equipment located in a patient's house was checked at initial assessment, and the patient was left with a telephone number to ring if they encounter any problems. Medical device alerts re: equipment were received and reviewed by the service.

The diabetes service used blood glucose meters and these were regularly maintained and calibrated by Leeds Teaching Hospital NHS Trust's medical physics department.

We found that equipment patients needed to manage their conditions and support their independence was delivered to them promptly.

Records and management

Requires Improvement

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Patient records were a mixture of paper based and kept in a patients' home and an electronic patient record. When patients had completed an episode of care, paper records were scanned onto the system prior to destruction, intermediate care and district nursing staff also needed to use paper records which were kept in patients' own homes to ensure records and care plans were available for all visiting members of staff.

Community staff were also required to complete an electronic patient record using SystmOne, which was an electronic patient record system for each patient. This meant there was duplication of records for patients receiving treatment at home.

During the inspection we found administrative staff were entering clinical information for district nurses onto SystmOne. We discussed this with district nursing managers who told us administrative staff entered information onto SystmOne to maximise the face to face clinical time. Since the inspection the trust have completed a risk assessment and added administrative staff inputting information onto SystmOne to the risk register.

We reviewed 16 sets of records and found them to contain the necessary information to allow staff to carry out clinical treatment, such as care plans and risk assessments.

Cleanliness, infection control and hygiene

All of the clinic facilities we saw were clean, well-organised and uncluttered.

The national staff survey highlighted that only 42% of staff said hand washing materials were always available which was lower than the national average for community trusts at 57%. However we found that hand washing materials including hand gels and PPE were available for all staff for use in the clinical area and for home visits. Staff reported they had access to sufficient personal protective equipment and equipment to support infection control.

We observed staff during clinic sessions and during home visits. Staff demonstrated a good understanding of infection prevention and control. District nurses were observed to use appropriate aseptic technique when changing wound dressings in patients' homes.

We observed staff clean their hands prior to and after care was provided, we saw appropriate use of gloves and aprons. Patients told us staff wore gloves and aprons when providing care and they had witnessed staff washing their hands prior to and following any examination or treatment.

Staff told us infection prevention and control environmental audits were completed.

Mandatory training

The trust had a key performance indicator for universal statutory/mandatory training. Compliance with universal mandatory training in June was stable at 89%.

The lowest level for the main six universal topics was fire training at 82.2%. 87% of clinical staff had completed both Mental Capacity Act and the safeguarding adults training. Compliance with conflict resolution training was 87%; and compliance with resuscitation training was 83%.

Staff reported there was good access to mandatory training and systems were in place to prompt them when this was due. However some staff told us they could not always access training because of work commitments.

Assessing and responding to patient risk

We saw clinical and environmental risk assessments were completed and followed for each patient. These included assessments for pressure ulcers, nutrition and mobility. Staff were trained and supported to use these tools and had access to other staff with more specialist knowledge or training when needed.

We saw evidence that patients had individual risk assessments in place, such as for the risk of falls, the risk of developing pressure ulcers and regarding pain relief. During a home visit, a district nurse was observed reviewing a patient's care plan and their risk assessments. We saw these were updated accordingly.

All staff we spoke with knew how to escalate risks to patients. For example, district nurses told us that if a patient was at risk of falls, they would refer patients to the falls team for a therapy assessment and they would order appropriate equipment to prevent falls.

Staff we spoke with were not aware of escalation policies for deteriorating patients. However, they could describe the

actions they would take if they were concerned with a patient's condition. The service did not use an early warning score system although we were informed there were plans to implement this.

Staffing levels and caseload

Managers and staff within the district nursing service did express concern regarding staffing levels and these had been on-going for some time. Some staff told us they felt under pressure due to staff shortages.

The staff survey identified that staff were working extra hours, for example 86% of district nurses stated they work extra hours and 16% of district nurses felt pressured to attend work when feeling unwell. 57% of district nurses reported suffering from work related stress in the previous 12 months.

Managers told us that they were trying to manage the additional pressure and had escalated the issues back to the trust's senior managers. Managers stated that staffing was "challenging"and that staffing levels "did not feel right". Managers stated that staffing levels were historically based, but that work had begun to determine safe nurse staffing levels through clinical activity profiling work.

The trust had 13 neighbourhood teams for district nursing and the trust had completed a district nursing service contact profiling exercise in August 2014 and the report identified 2,693 contacts were recorded by the district nursing staff during the one week exercise. As part of the exercise the trust reviewed district nursing daily activities and recommended that district nursing staff were allocated between 16 and 22 clinical units per full working day. A clinical unit was classed as 15 minutes of face to face contact with a patient. However, in some of the district nursing teams that were reviewed as part of the inspection we identified that staff were generally completing between 26 and 28 activities per full working day. Staff also told us the clinical units were for face to face contact only and did not include contacts with other agencies or referrals.

We reviewed the staffing rotas for some district nursing teams, and we found that actual staffing numbers were often less than the planned staffing numbers. We found staffing levels regularly fell below those required to meet patients' needs and shifts did not include the full range of staff skills needed.

For example we reviewed the planned staffing numbers against the actual staffing for Meanwood and Wetherby district nursing neighbourhood teams at the weekend. The Meanwood district nursing team had a planned staffing level of 1 band 6 nurse on a Saturday and Sunday. However we reviewed the rotas for October 2014 and found there was no band 6 nursing staff on duty any weekend during October 2014.

The service was twinned with Wetherby district nursing neighbourhood team (which provided support when the services were stretched) we found they did not have planned band 6 cover at the weekend however we found there was a band 6 nurse on duty during the weekend of the 11- 12 of October 2014 who could provide support across the neighbourhoods.

We reviewed the planned staffing numbers against the actual staffing for Meanwood and Wetherby district nursing neighbourhood teams for October 2014. There were a number of days where the planned staffing levels did not match the actual. For example for the Meanwood team on Wednesday 1st October 2014 the planned staffing levels were 19 staff (3- band 6, 11- band 5 and 3 – band 3 staff) however the actual number of staff on duty was 14 staff (0-band 6 staff, 10.66 – band 5 staff and 4.66 band 3 staff) and at Wetherby the planned staffing number were 9 staff (1 band 6, 5-band 5 and 3 band 3 staff) and the actual staff numbers were 9 staff (0.5 band 6, 5.52 band 6 and 3 band 3 and 0.52 band 2 staff.

The Trust was aware of the staffing issues within the district nursing service and there were a number of actions to address capacity and demand in progress.

The twilight team for district nursing team had recently moved from a central team to staff being devolved and aligned to the 13 neighbourhood teams. Following the restructure some staff had left and there was ongoing recruitment to cover vacancies. The teams were stretched across the Leeds area which put additional pressure on staff to cover visits. Managers said the main pressures were in the twilight shift (17:45 – 21:45). The trust provided evidence of action's in place to complete the transition to the new model.

We reviewed the staffing rotas some district nursing twilight shifts. We found for example in the Meanwood and Wetherby neighbourhoods 40% of shifts were covered by bank staff and 50% of shifts did not have a qualified nurse

on duty. Neighbourhood teams were twinned with other neighbourhood teams and would provide cross cover. However, there were examples in the Meanwood and Wetherby twinned teams where there were no qualified staff to cross cover. The staff that we interviewed were not aware of the process by which they could seek other cover arrangements if their twinned neighbourhood team was unable to assist them. There was a possible risk to patient care because there was not a qualified member of staff on duty who would be able to set up or monitor intravenous drips or administer medication.

Community matrons held a case load of patients at high risk with multiple, complex and deteriorating conditions. They saw their role as preventing patients being admitted to hospital. They said they worked closely with the local acute hospital trust to manage the discharge of patients effectively and coordinate their care.

Staff told us there was no community matron cover at weekends, bank holidays and some difficulty covering holidays. The trust indicated however that is was not commissioned to provide this service during weekends and bank holidays. This was mitigated by monitoring arrangements being put in place with the intermediate care team (ICT) and the district nurse team. Intermediate care team staff felt that while they were able to meet the patients' needs and keep them safe, this was not ideal for patients. The ICT told us that patients did seek aid from hospital services which may not have been necessary had they had access to a community matron.

Our observations of the community nursing teams when we accompanied them on visits were that they were well functioning and highly skilled.

The musculoskeletal service (MSK) manager told us staffing levels and vacancies was a concern. Staff in the MSK service told us that they had 11 vacancies which meant that their service was stretched. The staff felt that they continued to offer a safe service but this had been achieved by seeing fewer patients and this had adversely affected their referral to treatment time which they told us had gone from 2-4 weeks to 8-9 weeks. Recruitment was currently underway to fill these vacancies.

The trust had identified an increase in number of referrals and limited service capacity (2 who time equivalents) within the adult speech and language service leading to high caseload size and reduction in service levels, for example access to training.

The CCG had been monitoring the impact on the reduction of front line staff and the services provided by the trust as part of the cost improvement programme (CIP) monitoring. The CCG was assured about the quality assurance process which was currently in place to manage this.

Managing anticipated risks

The trust had a policy and procedures for maintaining staff safety when they were working alone. Staff were aware of the trust's lone working policy and knew what they should do to keep themselves safe when working alone in the community. Lone working arrangements were in place in each area. All staff that we spoke with about it safety considered important.

Managers told us staff provided their base with a list of their visits for the day. Staff phone or text to confirm they have started work. They then text or call at the end of the visit /day and the office checks them out. Staff confirmed they contact the office at the beginning and end of visits.

Risk assessments were undertaken for individual patients and staff reported they were acted upon. Patient visits were risk assessed and staff visited in pairs where needed. New / unknown patients were also visited by two members of staff.

District nursing staff told us they had concerns about working alone on a twilight shift. Staff told us on the twilight shift they should work in pairs to ensure staff and patient safety. Whilst the trust has indicated that there were city wide processes in place risk assess visits and the need for paired visits, and to provide staff cover, and neighbourhood teams twinned with each other, some staff we spoke with indicated that there were occasions when they requested a second colleague to attend a visit and had been told there was no one available, and that the twinning arrangements were not always effective as their twinned neighbourhood would be unable to assist.

Major incident awareness and training

Services had business continuity plans in place to ensure staff knew what to do to continue to provide services

Requires Improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

should a major incident occur such as IT failure, fire or flood resulting in loss of premises or in case of significant staff shortages due to outbreaks of infectious illness such as influenza.

Good

Are Community health services for adults effective?

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

Summary

Staff utilised evidence based guidance, and care was delivered using national quality frameworks.

Some of the trust's quality targets were not being met for some community services for adults with long term conditions.

A range of audits had taken place however some services had limited audit activity in relation to the outcome and impact of the services they provided.

Multidisciplinary team working took place across the organisation with good links across other primary medical and secondary acute providers.

Services had implemented a competency framework for staff to ensure they had the skills to provide care.

Detailed Findings

Evidence based care and treatment

Services provided evidence based care and treatments and used appropriate assessment tools and outcome measures. Policies and procedures followed NICE guidance and staff were keen to participate in research studies where appropriate. Staff from podiatry and MSK referred to working to their own professional body guidelines as well as using pathways from the Map of Medicine Health guides (MAPs) for medicine which they also referred GP colleagues to when appropriate. Healthcare professionals used these care maps as they showed 'best practice' – the most effective way to treat a health problem – based on up-to-date evidence of what works.

Multi-agency work and clear pathways were in evidence and specialist advice/ treatment or assessment was available when needed.

The trust had a range of policies and clinical guidelines available for staff. These were stored on the trust's intranet and readily accessible for staff in the community. For example the trust had policies and operating procedures in place in relation to positive handling, restraint, the Mental Capacity Act and the Deprivation of Liberties safeguards. The trust had a Mental Capacity Act 2005 (MCA): Policy and Guidance (ratified June 2013) and a Standard Operating Procedure (SOP) for the Deprivation of Liberty Safeguards (DOLS) (approved April 2014) and these policies applied to all services. Staff in the community was aware of these. Staff had all undertaken mandatory training for MCA, DOLS and staff understood their duties in relation to Mental Capacity Act and Deprivation of Liberty.

Pain relief

District nurses were observed to assess patients for pain and discuss pain control in depth. Pain relief intervention demonstrated patient choice and district nurses discussed the pros and cons of analgesia and side effect of drowsiness. For one patient the district nurses had helped a patient to determine an acceptable level of pain control which also avoided the patient becoming too drowsy and unable to carry out her usual daily activities.

The community falls service did not administer pain relief medication. They did review pain management as part of an assessment. They emphasised with patients the importance that pain was controlled to enable remedial physiotherapy.

The physiotherapist would remind patients of pain relief medication they may have forgotten to take. Staff described an example of a patient who could not move from sitting to lying without considerable pain and they had discussed the importance of taking pain relief medication.

Staff from the diabetes service told us they don't administer medication, but would identify the need for pain relief with patients, and signpost them to a GP.

Nutrition and hydration

The community falls service had patient nutrition and hydration needs included in falls risk assessments. The therapist role was to educate patients about hydration. If a patient was not eating and drinking, therapist would be asking why. The therapist would offer verbal advice and give the patient a falls advice booklet that had a section on diet and bone health.

Good

Are Community health services for adults effective?

The diabetes service clinical assessments would highlight any dietary issues and needs, which were discussed with the patient. The service would promote self-education with the patient. The 'Xpert' diabetes programme for patients was '60% dietary –focussed' and was used to increase "patient knowledge skills and understanding of their condition and help them to make lifestyle choices".

Use of technology and telemedicine

The IAPT service offered a range of services which included an option for patients to choose an online cognitive behavioural therapy programme.

Approach to monitoring quality and people's outcomes

The falls team used the Fall Efficacy Scale – International (FES-I) and TINETTI balance assessment tool on initial assessment and discharge to measure outcomes which were reported on quarterly.

Managers stated there was no outcome data available for the district nursing service. Information was put onto SystmOne but the system was unable to provide outcome reports. However the service was hoping to be able to produce outcome reports as part of the development of the use of SystmOne.

The neighbourhood team coordinators reported that they were working with GPs to reduce unplanned admissions as part of the CQUIN. No data was available yet.

There were CQUIN targets being completed by adult services. Three CQUINS were currently being reported as amber for the year end position, Community Matrons – Dementia, MSK AQP Clinic Cancellation and Safety Thermometer Improvement Goal.

There was a forecasted risk for community matrons dementia related to June performance for patients being screened for dementia. There had been a reduction in the number of patients on the caseload that had been screened for dementia. A plan had been developed by the service to ensure achievement rates had increased and were back on track for July.

MSK AQP Clinic Cancellation was rated as amber due a data quality issue in recording cancellations, which had resulted in a high percentage of appointments showing as being cancelled for non-clinical reasons. Work was underway by the service to address this issue and bring performance back in line for quarter 2.

The clinical pathway lead for wound prevention and management service told us that, in an effort to understand more about the incidence of grade 3 and 4 pressure sores in the community, a project was being undertaken to seek patients' views. One focus of the project was to better understand issues regarding compliance with use of pressure relieving devices and other recommended actions such as turning / positional change to alleviate pressure.

Across services staff were aware of the need to demonstrate effectiveness of care and interventions and routinely collected therapy outcome measures (TOMS) and other information relating to quality of life indicators. TOMS were recorded at assessment, after each visit and again at the end of treatment which meant improvements for individual patients could be monitored. However staff were frustrated that they were unable to usefully extract meaningful data back from SystmOne. There were some exceptions to this such as the healthy lifestyles team who with the help of the performance team had been able to extract reports to demonstrate the effectiveness of their services.

The improving access to psychological therapies (IAPT) team engaged in national, local and individual outcome measurement. Individual progress was assessed using measures such as PHQ (Depression Test Questionnaires), Social Phobia Inventory and GAD (Generalised Anxiety Disorder Assessment) scores and by tracking symptoms weekly, during therapy. Specific outcome measures were provided to the national IAPT database.

The targets for IAPT team had not been met and the service was now below the year to date target. For example the number of patients currently being referred and entering the service was below target; 5646 against the target of 6608. Secondly, the number of patients that had completed IAPT therapies and moved to recovery was below the commissioned target for number of patients seen. The service had identified actions and employed staff for six months to provide telephone screenings; individual step 2 therapy and step 2 group work to improve the number of patients to be seen.

However the IAPT team reported that they had very good outcomes from therapies provided and were starting to collect information regarding maintained recovery at 1 year post therapy. For example

695 patient referrals in quarter 1 for 2014/2015 finished a course of treatment, where the service user had moved to recovery. However the number of patients who had completed and moved to recovery was below target. The Specialist Business Unit was overseeing delivery of a recovery plan and all actions were being tracked on a weekly basis by the team and formally on a monthly basis through Performance Framework meetings.

Staff told us that they conducted regular audits of their services and we noted national audit information was collected to provide a comparison with the performance of other trusts regionally and nationally.

The services had completed audits which included;

- Patients with Ulceration Having Care Plan E Applied
- Wound Forms Completed Within the Patient Record
- Appropriate Use of Referral Pathways within the Podiatry Service for Non-diabetic and Diabetic Feet
- Annual documentation audit.

The trust documentation audit showed 75% of all audited patient notes were fully completed with an assessment of patient needs. An action/ treatment plan in relation to the identified needs including any risks and interventions being implemented according to treatment plan had been developed and were reviewed by the managers of the service.

Staff confirmed that regular records audits were undertaken. Results were immediately fed back to staff and action plans confirmed by email. District nurses also undertook 'spot checks' of their team's records. We looked at three spot check's which had been completed by the team manager and also the record of the meeting with staff to discuss the findings.

The podiatry service completed an audit assessing the use of the Visual Analogue [pain] Scale (VAS). The audit showed that the service did not routinely gather, measure or record pain scale variables in a robust and accurate manner that allowed them to demonstrate treatment outcomes. The audit reviewed all patients with a letter type "insole prescription" that was "sent" to them in a 12 month window to ensure effective insoles were prescribed and manufactured. Results from the audit were used to inform the new procedures being designed as part of a wider review of the trusts community podiatry insole provision.

Competent staff

The trust did not meet their target of 90% of staff receiving an appraisal in 2013/2014. The proportion of available staff at the end of July 2014 reported as having had an appraisal within the past 12 months was 87%. The July integrated performance report stated that the appraisal project plan was in the implementation phase and included links to work on talent management, behavioural framework/ values and pay progression. The trust had fully implemented the action plan and all community staff had received appraisals.

All staff told us that they were able to go on study leave and access training to improve their clinical knowledge and skills. Competencies were assessed using a formal witnessed, assimilated, supervised and proficient (WASP) assessment framework.

Staff attended service specific courses that were linked to their annual appraisal. A team leader gave an example of attending the professional leadership programme. A new member of staff explained that the trust had agreed to support day release for them to complete a master's degree.

Staff organised in-service training as a team; arranged outside speakers, and feedback to team members who do not attend.

The trusts' 2013/2014 Quality Account reported that the percentage of staff receiving clinical supervision fell in 2013/2014 and the trust did not meet its target. Clinical Supervision 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 consumer protection and safety of care in complex clinical situations' (DH 1993). The trust has stated that clinical supervision was one of their effectiveness priorities for 2014/2015.

Staff reported that they now received regular clinical supervision and found this useful. They were clear it was their responsibility to arrange this with their mentor. Some

staff had also received group supervision which they found beneficial. Staff told us they were encouraged to access clinical supervision and there were policies and procedures for clinical supervision.

Medical staff were required to complete a revalidation process. Revalidation was the process by which licensed doctors demonstrated to the General Medical Council (GMC) that they were up to date and fit to practice. The revalidation process required doctors to participate in an annual medical appraisal. The total number of doctors who were revalidated within the trust was 9/9. The total number of completed appraisals for all doctors and dentists in the trust was 73/81 (90%).

Managers for community told us new staff were fully supported; received induction and 4-week shadowing and support; clinical supervision quarterly, including a caseload review. New staff told us the teams were very supportive and approachable when help or advice was needed. We spoke with two staff who had recently been appointed within the service. They said they felt well supported and had been supported appropriately.

Multi-disciplinary working and coordination of care pathways

We saw good examples of multi-disciplinary working in the community teams. For example, close work with cardiac nurses and the acute trust in the management of cardiac patients to ensure continuity of treatment.

Community services had a partnership project with Leeds Leisure Services for people with long term conditions to help them to access exercise related activities.

There were weekly and monthly multi-disciplinary case management meetings held to discuss patients with complex health and social needs. These meetings were attended by, a consultant geriatrician, community matrons, district nursing team members, members of the intermediate care team and staff from social care. When necessary staff from other agencies or teams would also be invited to attend.

Community matrons told us they worked closely with local acute hospitals and social care managers for effective discharge of patients from hospital to community health services

Staff from the district nursing teams told us that they felt the integrated model worked well. The multi-professional teams had a mental health worker and social worker based in the office and they worked closely with the team.

There were neighbourhood team coordinators, a temporary pilot post, who liaised with external agencies such as voluntary services to provide appropriate care for patients.

Referral, transfer, discharge and transition

Referrals to the district nursing, intermediate care teams and joint care management teams were made through a central referral system (SPUR) or directly. Staff we spoke with who were responsible for accepting patients for district nursing and intermediate care were not aware of any specific written criteria for admission, but stated the service was predominantly for housebound patients and would discuss any patient that did not meet these criteria with more senior staff.

There was a coordinator in each neighbourhood that prioritised district nurse referral's and delegated them to staff with the appropriate skill mix.

Discharge from adult services was determined by qualified staff. When patients were discharged there were procedures for sharing information with their GP and other services such as social care. We reviewed discharge information for three recently discharged patients. We found that the discharges were planned in advance and involved an assessment of the patient's ongoing needs and to ensure patients received appropriate care at the right time.

Availability of information

A community matron newsletter and leaflet was available in braille, large print, audio or other languages. There was access to leaflets in different languages.

The electronic records system SystmOne was also used by most of the local GPs. This enabled timely access to relevant information. However some GPs used the EMIS electronic record and staff had to access the information through a separate electronic record. The trust was working to align the electronic systems to allow information to be accessed through one electronic record.

Consent

Good

Are Community health services for adults effective?

Staff reported that they obtained initial consent and then checked continuing consent at each visit.

We saw that patients were asked for consent and spoken with in a respectful way. Staff were observed to gain verbal consent prior to carrying out procedures and gave clear explanations to patients regarding what to expect.

Good

Are Community health services for adults caring?

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

Summary

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Information was provided to help patients understand the care available to them.

Patients were treated with kindness and respect ensuring confidentiality was maintained.

Patients felt included in decision making, listened to and were able to express opinions, which were taken into account. Patient independence was respected and encouraged.

Detailed Findings

Dignity, respect and compassionate care

During our visits to patients, staff were observed to treat patients with compassion and respect and maintained patients' dignity throughout interventions. It was evident that district nurses had developed caring relationships with their patients and understood their individual needs and circumstances. Nurses were observed to enquire and gather information about other aspects of care and treatment a patient was receiving to enable a holistic view. Patients told us they felt respected and treated with dignity.

The district nursing administrator was observed taking telephone calls from patients in a polite and caring manner, messages were immediately passed on and patient was called back with response.

Staff said they felt that patients were "at the centre" of care delivery.

Patient understanding and involvement

We observed patient appointments in a clinic and patients were included in their consultations. Staff asked the patient for their views and patients told us they felt listened to. For example we observed staff using diagrams to explain how carbohydrates and sugar was absorbed in the body. The member of staff gave clear advice, re-assured the patient and asked the patient if they had any questions.

A mixture of face to face and telephone interviews were carried out with patients and carers who told us they felt safe. Patients reported that staff were supportive, understanding and flexible.

Patients and relatives we spoke with all indicated they were involved in care decisions, and records we reviewed confirmed this. All records we reviewed contained evidence of consent from patients for treatment. We found all the services delivered person centred care and that people, their relatives and/or representatives were involved and central to decisions made about the care and support needed.

Emotional support

All staff we spoke with told us that part of their job was to provide emotional support not just to patients but also their carers and families. During home visits staff demonstrated knowledge of people and their unique situations and provided tailored emotional support.

Promotion of self-care

Patient's independence was respected and actively encouraged. We noted that achievable and realistic goals were set with patients attending the services, for weight reduction, smoking cessation and healthy life styles including exercise.

Patients had been given self-help numbers and direct line numbers for staff and felt that the service was accessible. Patient felt listened to and that they had input into their care plans. Patients felt that their treatment had been excellent and they were treated with dignity and respect.

The IAPT service offered a range of services to people suffering from, depression, complicated grief, stress, anxiety through individual and group therapies.

Waiting areas in clinics had a range of information on conditions, self-help and healthy lifestyle / health promotion.

Good

Are Community health services for adults responsive to people's needs?

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

Summary

People were able to access care and treatment close to home in local clinics and treatment centres.

Some services were short staffed and were managing increasing workloads, but were still meet waiting time targets.

Community nursing services were flexible and worked across professional and organisational boundaries.

We found staff had good working relationships with partner organisations, such as social services and the voluntary sector.

There were systems in place within all teams for learning from experiences, concerns and complaints.

Detailed Findings

Planning and delivering services which meet people's needs

Managers we spoke with for each service were aware of the risks in their areas such as staffing levels and skill mix, geography of the various sites, and investment in community services.

A nurse coordinator, supported by a member of administrative staff, was responsible on a daily basis for managing the workload of the team.

Community matron's work focused specifically on patients who had complex and multiple needs and who were at high risk of re admission to hospital. Community matrons retained contact with patient's who did not currently need the service but whose pattern of need indicated that was changeable. It was noted that the service was only commissioned to provide care Monday to Friday 9:00 to 17:00.

Equality and diversity

Staff and managers had undertaken equality and diversity training as part of their mandatory training.

The services had arrangements in place to enable patients to access services. For example we observed that the service had ensured an interpreter and signer was available for an appointment with a patient with complex needs.

Meeting the needs of people in vulnerable services

Community matrons' work focused specifically on patients who had complex and multiple needs and who were at high risk of re admission to hospital. However the service only provided care Monday to Friday 9:00 to 17:00 patients contacted out of hour's services in the evenings and at weekends.

The service in conjunction with the voluntary sector had developed a directory to support and promote advocacy in Leeds. These services had been developed to support different groups of patients. For example the district nursing and community matrons provided information about Carers Leeds who are able to give practical help and support for patients and their families.

We saw that throughout the trust there were information leaflets available on various conditions, how to access services and they types of support available. There was an interpretation service available for staff to access which included language line and interpreters who would attend visits and appointments as necessary. Staff confirmed that they could access interpreter services for patients.

All services had access to a dedicated telephone line was provided to patients to enable them to access the service and speak with someone from the team.

Staff confirmed that risk assessments were undertaken for individual patients to enable them to meet their needs. The Integrated Care Team gave an example of how they had developed a close working relationship with one of their patients suffering from a long term condition, to facilitate readmission to their service when needs escalated. Assessment of this particular patient was based on risk and prompted short term interventions through periods of exacerbation. Further risk assessments were undertaken prior to withdrawing ICT support as self-care was re-enabled.

Good

Are Community health services for adults responsive to people's needs?

Services took account of the needs of people with complex needs, for example those living with dementia or those with a learning disability. For example the cardiac service had produced an easy to read booklet for patients.

Buildings were accessible and adhered to the Disability Discrimination Act (DDA) 1995. The act aimed to end the discrimination that impacts on many people with disabilities.

Staff reported that joint visits with carers and family members were undertaken for vulnerable patients. We observed visits to patients who required complex wound care with family members present. There was good communication on the progress of the care being discussed with the patient and their relatives.

Access to the right care at the right time

Services were offered from a range of locations across Leeds including, health centres, GP practices, leisure centres and other community buildings, many of the services also offered domiciliary visits to deliver care. Patients had a range of choice regarding how and where to access services. Patients could choose between different locations for some clinics to reduce travel.

Community matrons saw their role as crucial in ensuring a smooth transition for patients from hospital to home and preventing hospital admissions. At the community matron focus group they highlighted a case study which highlighted the care and support given to a patient had prevented frequent A&E attendance.

100% of patients met the 18 week target for referral to treatment for non-admitted & incomplete pathways. No patients waited more than six weeks according to the NHS England statistics for diagnostic waiting times.

MSK services aimed to offer appointment 4 weeks from referral although this had slipped recently to 8-9 weeks due to staff vacancies. Patients were able to choose place and time of treatment through Choose and Book. Patients could also refer themselves into the MSK service.

Waiting times for podiatry were reported as 4-12 weeks depending on which specialism and managers told us that although there had been some breaches of the 18 week wait target, these were down to administrative errors and patients lost in the system rather than being due to and inability to meet demand.

IAPT services operated a telephone consultation to patients and could respond very quickly to patients who had urgent need for intervention. 85% of referrals were seen within 28 days of referral. In the majority of cases patients could be offered an appointment within 2 weeks. A quick response was recognised as being extremely important to the success of therapy as there was a need to engage with patients at the point of readiness to change.

Data was requested but was not collected by the service or available to indicate the number of patients seen within certain time frames from referral. There were occasions when patients were cancelled due to workload pressures, but no data was available to confirm this**.**

Complaints handling (for this service) and learning from feedback

Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at service level or through the trusts Patient Advice and Liaison Service. Training for staff on complaints was provided.

Staff were aware of how to handle complaints and stated they received feedback via the team meetings.

Although patients had not heard of PALS and did not know how to make a complaint, they expressed that they would feel comfortable raising any concern with their nurse or nurse manager if needed.

Good

Are Community health services for adults 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

Staff knew the vision, strategy and objectives for the trust.

There were service and team meetings which included items on risk, safety and quality.

There were systems for recording and managing risks; managers were approachable and visible.

Staff and teams worked collaboratively to deliver quality care.

The services sought out and acted on feedback from patients.

Detailed Findings

Service vision and strategy

The trust vision was displayed in all offices. The Integrated Performance Report in August 2014 linked the vision for the trust to four objectives. Staff were aware of the service vision strategy and objectives.

There had been a recent management restructure. Further restructure of the services was planned and staff were aware of this. Many staff were concerned about the number of service reviews and changes that had taken place and felt that changes were difficult to embed because of this.

Most staff were supportive of the changes however some staff told us they were anxious about sustaining services city wide especially with the district nursing twilight service.

Governance, risk management and quality measurement

The risk management strategy has recently been reviewed and updated. Each service had access to a local risk register and local risks were discussed at team meetings. The clinical lead within the neighbourhood team attended the trust's-wide quality committee.

Records of team meeting demonstrated that risks at team and management level were identified and captured and staff recognised their role within the importance of risk management and improving the service. The district nursing forum in October 2014 discussed the need to reduce some of the pressures on the district nursing teams. The forum identified and agreed actions to reduce the pressure on staff. The minutes from the district nursing forum were discussed at district nursing team meetings in October 2014.

Staff recognised that learning from serious incident occurred, but there was a need to learn from lower level risks. Adult services had 329 incidents which still needed the incident investigations to be completed. There could be a risk that lessons learned from incidents were not shared with teams timely and effectively. The trust submitted an action plan detailing their planned improvements to the management of risk.

The percentage of staff in the 2013 national staff survey who stated that they were satisfied with the quality of work and patient care they are able to deliver was similar to the national average. All staff told us they who would recommend the trust as a place receive treatment.

The trust had integrated key services delivered by the adult services business unit, and monitored the impact of the new service configuration using quality markers such as incidents complaints and pressure ulcers.

Leadership of this service

Staff commented that the new chief executive had recently started. They were aware of the CEs weekly bulletin and the "Ask Thea" email system for staff to ask the CE questions. Many nurses also commented on the visibility and support of the senior nurses. Staff told us that they could use the Ask Thea function on the intranet to raise concerns with the chief executive if needed.

Managers at service level in clinics and community teams were visible and staff told us their managers were approachable. Managers and staff within the integrated care team felt senior leadership/ board members were visible. Staff reported a positive culture with in the service

However the staff survey for 2013/2014 stated the percentage of staff who reported good communication between senior management and staff was 24% for district nursing and MSK staff and 45% for other adult's services.

Good

Are Community health services for adults well-led?

The clinical lead within the neighbourhood team attended the trust's-wide quality committee and share any learning and developments at team meetings.

All services had team meetings where incidents, complaints, local risks and service developments were discussed. Learning from incidents and complaints were discussed. Staff recognised that learning from serious incident occurred, but there was a need to learn from lower level risks.

Culture within this service

The services we inspected were open and transparent regarding incidents and complaints and all staff were focussed on delivering the highest possible standard of care to their patients. However, staff and managers expressed a weariness regarding continuing change and restructure.

Leeds Community Healthcare NHS Trust staff sickness rates were above the national average for community trusts. Sickness absence showed a significant change in July 2014, at 5% against a target of 4%, as a result of further long term sickness absence. An improvement on this position had been recorded in August 2014. A concentrated piece of work was underway to establish the reasons for sickness absence, with management support being offered to affected staff.

A non-executive director had expressed concern in the increase in long term sickness. It was noted in a Board meeting that much of the long term sickness was stress related which could be attributed to service reviews and high spend on agency and bank staff. The director of workforce had benchmarked against ten actions to be taken in order to improve sickness absence in the NHS in response to previous enquiries by the business committee.

Fit and proper person requirement

Managers and staff reported that recruitment checks were in place and undertaken.

Public and staff engagement

The trust engaged with staff through quarterly staff surveys, listening events and weekly bulletins. Most staff reported a positive shift in culture in the organisation. Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority. Staff told us they were encouraged complete quality challenges to review patient care. The quality challenge reinforced CQC domains and were used to increase team learning and was shared through development sessions and service meetings.

The percentage of staff who felt able to contribute towards improvement at work was similar to the national average although respondents from the musculo-skeletal staff were less positive for this indicator. 76% of district nurses, 52% of MSK staff and 84% of other adult services staff felt able to contribute to improvements at work.

Records showed services sought feedback from patients who received care in community settings or in their homes. We reviewed patient surveys in respiratory, podiatry and district nursing services. Results from the surveys showed patient feedback was positive.

The adult business unit's patient satisfaction score was 94% in August 2014. The cardiac service falls service, community neurology services, continence urology and colorectal services, respiratory service, and diabetes service scored 100% for patient satisfaction. District nursing scored 96% and wound prevention service score 83%. The Board noted the strong performance against the majority of services in August 2014.

Innovation, improvement and sustainability

There was a focus on improvement of services. Staff were encouraged and supported to provide services innovatively.

The CCG stated that it was continuing to engage with the trust in the establishment of a program of scheduled visits within all services provided. For example a visit to community matrons was scheduled for mid-September to support innovation, improvement and sustainability of services.

The trust has an innovation and research newsletter and forum which highlights work. Speech and Language staff had helped with the development of a mobile phone app to support people who stammer. Over 70 reception staff have been trained to help support patients who stammer who attend health centres.

Staff from the Leeds continence, urology and colorectal service had produced a video to launch the new national bowel care guidelines.

Good

Are Community health services for adults well-led?

The trust was working with partner agencies to implement a new model for integrated health and social care for adults in Leeds. Social workers were aligned and worked within the neighbourhood teams to provide a more person centred service.

The tissue viability service achieved second prize at the British Journal of Nursing Tissue Viability Team of the Year Award 2013.

Two Leeds arrhythmia nurses were invited to the House of Commons for the launch of the 'GRASP the Initiative' (The Guidance on Risk Assessment and Stroke Prevention - Atrial Fibrillation) report. Staff were working to promote the initiative with GP practices in Leeds and assisting them with the running of the tool, assessing patient's suitability for anticoagulation and running practice based clinics to advise patients and

start their treatment.

Staff from podiatry, district nursing and occupational therapists had received Winter Heroes awards. The awards scheme was designed to recognise the work that NHS staff had undertaken over the winter period – with many staff braving the elements to continue to deliver high quality care in the snow, rain, wind and sub-zero temperatures.

Community staff were involved in a project 'Dancing into the 3rd Age', which aimed to explore the role dance can play in the health and wellbeing of older adults. This was collaboration between the trust, Yorkshire Dance and The University of Leeds.

Within the IAPT service, following patient requests and feedback asking for more information, before start of treatment, 3 pre-CBT seminars have been introduced to enable patients a better understanding of the therapy. Staff told us that engagement with these sessions has improved the delivery and effectiveness of the therapy as patients already understand and are ready to commence the therapy.