Barnet, Enfield and Haringey Mental Health NHS Trust

RRP

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRPX	Trust Headquarters	Adult community services in Enfield	**N15 3TH**

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health 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 Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good

We rated the adult community health service as **good** because:

We observed staff treating patients with dignity and respect. Patients told us they had received good and compassionate care. Teams respected the individual needs of each patient including their religion and culture. We saw examples of teams taking different approaches to respond to people in vulnerable circumstances.

Staff were aware of the trust values and told us these resonated with team values and approach. Staff consistently reported they felt well supported by team leaders and senior managers. Staff felt valued and respected by the organisation. Staff told us they felt safe in their work and had arrangements in place for lone working.

There were examples of innovation and close working with the local commissioners. The trust annual awards celebrated such developments.

There were arrangements in place that promoted the safety of patients and staff. Teams learned from mistakes made and had a culture of openness and transparency. Staff received training to help to keep people safe. Staff told us they felt well supported, had access to regular supervision and annual appraisals. They were able to undertake training to develop and maintain their clinical skills. There were good examples of multi-disciplinary working.

The teams were monitoring how services were delivered and whether they met the needs of patients. Local and national audits were undertaken. A range of measures were used to evaluate the outcomes of patient treatments.

Summary of findings

Background to the service

Information about the service

Enfield community services transferred to Barnet, Enfield and Haringey Mental Health NHS Trust in January 2011. The adult community health services included:

Community matrons

Intermediate care teams

Care home assessment team (CHAT)

Community physiotherapy

Musculoskeletal physiotherapy

Podiatry

Nutrition and dietetics

Adult speech and language therapy

Heart failure specialist nurses

Lymphoedema specialist nurses

Respiratory services

Parkinson's services

Stroke rehabilitation

Continence specialist nurses

Diabetes specialist nurses

Tissue viability specialist nurses

Our inspection team

The team that inspected adult community services consisted of CQC inspectors an Expert by Experience, two district nurses and a continence nurse.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive hospital inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits on 1, 2 and 3 December 2015.

During the visit we did the following:

- Spoke with 82 staff including nurses , therapists, team leaders and senior managers who worked in the service, either individually or in focus groups.
- Joined staff on six home visits and attended two clinics and observed how people were being cared for.
- Spoke with 38 patients on home visits, in clinics and by telephone who were receiving a range of different services.
- Reviewed eight treatment records of people who use services.

Summary of findings

What people who use the provider say

We spoke with 38 patients on home visits, in clinics and by telephone who were receiving a range of different services. Staff were well thought of and patients consistently told us staff and the service were excellent. Patients told us they thought staff were very professional and well trained and spoke about staff explaining treatment to them.

Patients described their experience of care very positively saying the staff were very friendly, supportive and met their individual needs.

We heard about most appointments being on time and staff explaining the treatment that was being provided.

One patient commented on staffing levels and said 'staff don't have time to themselves between patients'.

Some patients told us the appointment system in the podiatry clinic was not always effective and not receiving appointment letters. Other patients told us the appointment system worked well. Patients also spoke about often having to see a different podiatrist each visit when they would have preferred to see the same person.

Good practice

- The GP integrated multi-disciplinary risk stratification meetings had led to effective multi-disciplinary work to meet the needs of patients with the most complex needs.
- The care home assessment team was providing effective support to people in care homes and helping to reduce acute hospital admissions and visits to accident and emergency departments.
- The diabetes team had developed 'living a healthy life': an education, monitoring and screening programme for adults with learning disabilities. This work was commended in the 2013 diabetes quality in care programme

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should continue to work towards recruiting more permanent staff, particularly in the district nursing teams to ensure there are sufficient staff to meet the needs of the patients.
- The trust should continue to encourage staff to complete their mandatory training in line with the targets set by the trust.

The trust should continue to ensure staff have the right equipment and premises to carry out their work. This includes having access to consistently working mobile phones, an ability to complete patient notes and download them remotely and sufficient desks with access to computers when they are in the office.

Barnet, Enfield and Haringey Mental Health NHS Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

We rated safe as **good** because:

- Staff were aware of what incidents should be reported and there was learning from these incidents and action taken.
- Staff were aware of keeping people safe and how to report any safeguarding concerns.
- Staff completed risk assessments to make sure patients were safe from risk of harm.
- A contracted company undertook equipment checks and maintenance and these had been completed.
- Records were generally of good quality but there was duplication of notes due to some staff keeping both paper and electronic records.
- Infection control practices were followed in clinics and home visits.
- There were lone working polices in place for staff and arrangements in place to keep staff safe.

However, the trust identified recruitment of staff as a risk and some teams, particularly district nursing and some therapies had high caseloads and staff vacancies. However, we saw the trust had taken action to minimise the risk to patients. There were active measures in place to recruit staff to vacant posts or identify staffing shortfalls.

Detailed findings

Safety performance

- The trust reported no never events between September 2014 and September 2015.
- The NHS safety thermometer provided a monthly snapshot of areas of harm including new pressure ulcers, falls with harm, catheter and new urinary tract infections (UTI's). Between September 2014 and September 2015, new pressure ulcers fluctuated with a high of 12 in July 2015 and a low of one in December 2014. The number of recorded falls with harm fluctuated with a high of nine in June 2015 and a low of one in four other months. The number of new UTIs also varied with a high of five in July 2015 and none in 7 months.

Incident reporting, learning and improvement

Good

Are services safe?

- The trust reported 39 serious incidents between September 2014 and September 2015 for adult community health services. The most frequently occurring serious incidents were pressure ulcers, of which there were 34 incidents reported. There was one insulin drug incident.
- The serious incident reports showed recurrent themes of incomplete or absent documentation, minimal communication between community staff and carers and delays in patients receiving pressure-relieving equipment.
- District nurses told us pressure ulcers were the highest reported incidents. They completed incident reports for all pressure ulcers graded as two and above. Investigations took place of all grade three and four pressure ulcers, including ulcers acquired whilst the patient was in receipt of care, in hospital or just receiving input from the GP. Staff across all the adult community teams including therapists, were aware of the incidence of pressure ulcers and that they needed to be alert to patients who may need support with pressure care.
- The clinical, quality and safety report presented to the trust board in November 2015 noted three of the six district nursing teams had made presentations at a forum to discuss pressure ulcers. This showed their progress with the implementation of the pressure care audit action plans. The meeting agreed actions to further reduce the numbers of pressure ulcers. The forum also had a presentation on a framework to prompt a holistic assessment of care developed by a specialist district nurse. The group received information on a new concept in pressure care mattresses.
- We looked at the root cause analysis report of a pressure ulcer serious incident investigation published in August 2015. This was a detailed and comprehensive report and included a patient timeline, patient risk factors, assessment and management, organisational factors and care and service delivery problems. A six-point action plan with a record of when the actions were completed was included. We saw a root cause analysis investigation report for an insulin medicine error in March 2015. The report identified two lessons learnt and made recommendations on sharing the learning. District nurses showed us an information sheet developed in response to this learning and used to remind staff about the safety checks they must follow before they gave nursing care or treatment to patients. We joined staff on home visits and saw these sheets on the front page of the patient's file.
- All band seven staff were trained to investigate incidents. They had received in house training by an external facilitator to undertake serious incident reviews.
- Therapists completed reports for incidents such as slips, trips and falls, swallowing concerns, no follow up from other services and information technology issues. When non-availability of equipment impacted negatively on patient care especially over long weekends this was also reported.
- Staff discussed incidents and action plans in their team meetings, monthly management meetings and the pressure ulcer forum. The focus was to learn from incidents and to receive additional training if needed. Team leaders and senior managers discussed incidents at "deep dive" meetings held every quarter. An example was given of a change in practice resulting from an investigation of an incident that highlighted inconsistency in reporting. This resulted in clarification about what information staff should enter in to the computer based patient information system.

Duty of Candour

- The root cause analysis completed after a serious incident reported whether the patient and their carers had been told about the incident and how this was being addressed. This enabled the trust to check whether it was compliant with the duty of candour.

Safeguarding

- Trust mandatory training included adult safeguarding levels one and two, children's safeguarding levels one and two and children's safeguarding level three. Only staff who investigated safeguarding alerts were required to undertake level three children's safeguarding. Compliance for staff working in adult community health services was 83.5% for adult safeguarding, 85.5% children safeguarding level one and two and 55.2% safeguarding children level three.
- Managers were confident teams knew when and how to report concerns about safeguarding including how to contact the multi-agency safeguarding hub. Staff were

aware of reporting processes for safeguarding concerns. Safeguarding was discussed at team meetings including potential safeguarding alerts and also how to protect vulnerable individuals.

Medicines

- The trust was working towards all district nurses being trained as non-medical prescribers. Community practitioner nurse prescribers can prescribe from a limited formulary. Staff said they were being supported to complete this training.
- A district nurse told us they had intravenous therapy (IV) one day training with the trust. They then went out with a competent member of the team and was supervised until assessed as competent. Staff had annual intravenous therapy training updates.
- A district nurse manager said there was close working with pharmacists. The trust formulary had a prescription request for GPs to prescribe and many chemists delivered the prescription to the patient. Nurses were encouraged to keep the GP signed medicines sheet rather than transcribe.
- On a home visit with a district nurse we observed a control drug stock check was undertaken based on NICE guidance including the drug, doses given, expiry date, batch number and amount discarded. They told us trust policy stated one competent experienced nurse could set up and refill a syringe driver. However, nurses could go in pairs if they wished even if they had achieved their competency in the use of syringe drivers.

Environment and equipment

- A contracted company undertook medical device maintenance and they held the medical device register. The stickers on devices showed equipment had been serviced within the specified date. Staff we spoke with said the company was proactive in completing these checks.

Quality of records

- Staff had access to the trusts confidentiality policy.
- District nurses kept on-going patient notes in the person's home. They electronically recorded any changes in the patient's condition and any incident reports. The district nursing notes were comprehensive. There were holistic assessments including potential areas of risk such as pressure care. There was a record of contacts with the patient. Care plans were prepared and we saw the patients had signed some. Patients with long-term chronic conditions had a routine yearly re-assessment.
- We reviewed notes of five patients seen by the lymphoedema service. We spoke with the nurse consultant who explained that a holistic assessment was completed with the patient and a plan of care discussed with them. The plan of care was in the form of a letter sent to the patient and all professionals working with them. We saw assessments were not fully completed and there were gaps in information recorded. The impact of this was mitigated by the care plan letter which was much more detailed although details of frequency of care and treatment for example how many times a day cream should be applied and frequency of dressing changes was not recorded in one letter. Some hand written notes were not always legible.
- With the consent of the patient, we went on a home visit with a therapy assistant. Therapists recorded patient notes in the trust electronic patient information system and did not keep written notes in the patient's home.
- We saw tissue viability documentation was completed with patient consent forms, photographs, wound mapping and patient centred goals identified and recorded.

Cleanliness, infection control and hygiene

- Staff had access to the trust infection control policy and fact sheet.
- Staff had all the personal protective equipment they required and regular checks of equipment were undertaken.
- We observed infection control procedures followed in all cases. Staff followed hand washing protocols and infection control procedures including the appropriate use of personal protective equipment. They cleaned equipment with clinical wipes before putting them away.
- Community matrons discussed infection control at the meeting we attended.
- At the lymphoedema clinic, staff completed a monthly cleaning audit of each clinic room. The audit included floors walls, ceilings, equipment chairs and tables. We observed couches, trolleys and chairs cleaned by the

nurse with clinical wipes between patients and clean stickers attached. There was a washbasin, liquid soap, hand gel and paper towels in place and a supply of gloves and aprons.

Mandatory training

- Trust mandatory training included conflict resolution, equality and diversity, fire safety, health and safety, infection control, information governance, resuscitation level 2 - adult basic life support and automated external defibrillation, safeguarding adults level 1 and 2, safeguarding children level 1 and 2, safeguarding children level 3
- Figures provided by the trust showed overall compliance for community services was as follows. Community matrons 87.4%, podiatry 92.4%, speech and language therapy 100% physiotherapy community - adult 77.1%, bone health service 100.00%, physiotherapy out-patients 79.1%, dietetics 100%, diabetes 82.59%, district nursing out of hours 90.6%, lymphoedema 100.00% respiratory diseases 93.6%, tissue viability nurse 74.1%, heart failure nurse 74.1%, intermediate care 84.2%.
- Six of the trust's adult community services did not meet the trust target of 85% for compliance. Since August 2015 the trust had implemented a number of measures to ensure mandatory training compliance was met. In October 2015, the trust reported an overall compliance rate of 79%.

Assessing and responding to patient risk

- Risk assessments were completed to ensure patient safety such as Waterlow assessments (a tissue viability assessment tool) and MUST (malnutrition universal screening tool) and patient handling risk assessments.
- Staff undertook assessments of patient risk and identified action to reduce risk. For example on a home visit with a tissue viability nurse, we saw pressure relieving equipment was ordered by the district nurse. There was a care plan for increased bed rest for pressure relief and reduction of leg oedema. In the lymphoedema service, patient wounds were assessed and Royal Marsden clinical best practice guidance was followed in preparing individual care plans.

Staffing levels and caseload

- All staff we spoke to at all levels in the adult community health services told us recruitment of staff was the biggest challenge.
- The trust reported staff turnover for adult community services was 9.8% as at 31 July 2015. The figure for the whole trust over this period was 12.8%.
- The trust risk register included specific reference to recruitment of district nurses. The action plan included such things as improved links with universities and graduates to ensure the trust attracted and retained newly qualified staff. Local recruitment activities took place including coffee mornings and stands at recruitment fairs and in shopping centres. An international recruitment campaign in Poland for mental health nurses, health visitors and district nurses was taking place. The trust was developing its capability for continuous international recruitment through use of the Guardian and skype technology for interviews. There were plans to develop links with overseas universities.
- Staff told us it was especially difficult to recruit band six nurses with the required experience and occupational therapists and physiotherapists tended to prefer locum posts. There had been an occupational therapy vacancy for over four months.
- Some staff also felt some applicants may have been deterred from applying for posts because of the emphasis in advertisements of the trust being a mental health trust. The trust had recognised this and changes had been made to recruitment advertising to address this.
- Teams used bank staff and where needed agency staff to cover shifts. The use of agency staff was restricted to six agencies. Figures provided by the trust for three months before the inspection showed 154 (35%) of shifts were covered by bank or agency staff in the out of hours district nursing team. Five hundred (11%) of shifts were covered in the district nursing team and 106 (2.4%) of shifts were not covered in this period.
- The whole time establishment for the district nursing team was 100 staff at the time of our inspection and there were 84 staff in post. District nurses had the highest vacancy rate in the adult community services with 16 whole time equivalent vacancies. One member of staff had been on long-term sick leave. We were told band five nursing staff were generally easier to recruit than band 6 staff.

Good

Are services safe?

- The trust provided opportunities to develop staff. Every year the trust sponsored district nurse training and five staff had trained this year. All band seven staff were practice teachers.
- A district nurse manager said staff were predominantly allocated on a geographical basis. Each district nursing team had a weekly meeting and informed the administration team leader of staff required each day to cover shifts. On occasions, staff would support colleagues in other teams. The manager said the system was effective at present but the trust would be evaluating a new locally tailored operational scheduling tool.
- Patients were prioritized and those requiring insulin or palliative care were always seen, although we were told it was "very rare" for patients not to be seen as required.
- Out of hours district nurses said the bank team was supportive and responsive and would work at very short notice if required. For example, if a member of staff went sick whilst on duty a colleague would help out.
- A district nurse manager said caseloads were "manageable" but were "heavy" for staff. Teams could have caseloads of 300 to 400 with one nurse visiting 12 or more patients in a day. The teams covered a large geographical area with a diverse and older population. A Kings Fund survey of district and community nurses in 2013 (commissioned by the Royal College of Nursing) published June 2014 showed on average respondents reported having seen nine patients on their last shift with 25% of respondents reporting that they had seen 12 or more patients.
- District nurses told us teams' caseloads were 'stretching staff to the limit'. They were working with patients with more complex needs and there was a high turnover of staff often due to nurses moving from district nursing to other specialist nursing services. District nurses we spoke with told us the guidelines for staff was to stick to working hours but they said staff often worked through lunch breaks and extra hours. District nurses could not say no to referrals and there was often a need for a rapid response. GPs expected district nurses to support practice nurses' patients when the practice nurse was on holiday or off sick, which added additional pressure to their workload. They told us this was a nationwide problem and not specific to this trust. Staff said the trust managers were aware of the challenges and supportive.
- Therapy team managers used agency staff to cover vacancies, especially occupational therapists. Figures provided by the trust for a three-month period before the inspection showed agency or bank staff covered 32 shifts and 22 shifts were not covered. This equated to around 2.4% of shifts covered by agency or bank staff and 1.6% of shifts were not covered.

Managing anticipated risks

- The trust had a lone worker policy. Staff said there were lone working procedures in place in their teams. Staff considered risk when planning home visits and could do joint visits if needed. Twilight district nurses would be piloting electronic lone working devices in the near future. Staff called the office to keep them updated on where they were. The teams had a "safe" word to alert the staff in the office if they had concerns and had to telephone in the presence of the patient. Out of hours staff contacted each other by text and could contact team leaders if needed.

Major incident awareness and training

- District nurses told us there was an adverse weather plan when staff would go to the nearest base to their home and inform the team leader where they were covering.
- We saw the bronze action tactical command information displayed in a staff room that outlined how to respond to a major incident.

Good

Are services effective?

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

We rated effective as **good** because:

- Teams followed NICE guidance and evidence based practice.
- We saw good practice of staff assessing and responding to patients in pain.
- We saw teams used a range of outcome measures to evaluate the effectiveness of their work.
- Staff had good access to training were well supervised and had annual appraisals.
- We saw good multi-disciplinary and multi-agency working. There were clear patient pathways in place.
- Community matrons, district nurses and intermediate care teams had a single point of access with a streamlined referral processes.
- The trust had an electronic patient information system.
- Staff asked patient consent prior to undertaking treatment and were aware pf processes to follow if a patient did not have capacity to give informed consent.

However, there were some real challenges in terms of the technology supporting community work. This included mobile phones frequently not working, staff not having remote access to write up patient records and in some places a shortage of 'hot desks'. The trust was working to improve mobile working for community staff.

Detailed findings

Evidence based care and treatment

- New national guidelines were cascaded to team members through team meetings and NICE guidance was available on the trust website. If the service was not compliant with the latest guidance they developed an action plan which the trust clinical governance team monitored.
- We saw examples of guidance being used. For example at the lymphoedema clinic we saw NICE guidance on bariatric care being followed.
- Another example was the use of NICE guidance for patients with type two diabetes. This recommended patient education as a key priority for implementation. The diabetic team ran 11 interactive education sessions a year consisting of one afternoon a week over three weeks to support patients to manage their own condition.
- Another example was at the heart failure clinic where the care plans and protocols were based on NICE guidance. The team also received updates from the British Heart Foundation.
- The dietetic service was using evidenced based practice. For example they were involved in a "healthy weight group" working with a range of other partners including the local authority, charities, sports development and catering services to develop a local strategy to reduce levels of obesity.

Pain relief

- Patients were assessed for their level of pain. Pain assessments were discussed at district nurse handover meetings.
- Staff were very aware of each patients level of pain. We observed staff waiting for pain relief to be effective before starting treatment.
- District nurses were trained to administer pain relief, for example for patients receiving palliative care.

Nutrition and hydration

- Patients were assessed using the malnutrition universal screening tool (MUST). The district nursing and dietetic teams were looking at the possibility of a mobile phone app to support the use of this assessment.
- Relevant people had reviewed a recent nutrition and dietetic NICE guidance update. The group confirmed the service was compliant with the new guidance.
- The dietetic service offered on the job training including nutrition updates for district nurses and care home staff.

Technology and telemedicine

- District nurses did not use telemedicine. Specialist nurses used telemedicine for patients with chronic obstructive pulmonary disease (COPD) and for patients with heart failure as part of an ongoing clinical trial.

Good

Are services effective?

- As part of the integrated community service there was a scheme where nurses could refer patients who would benefit from the use of telecare.

Patient outcomes

- The Enfield community stroke team had provided the data that was available to the sentinel stroke national audit programme (SSNAP). Staff were involved in pan London 'life after stroke' meetings which reviewed the progress of this audit. Data from the SSNAP report for the stroke rehabilitation team from October 2014 to March 2015 showed 22 patients were discharged or transferred over this period. All the patients had rehabilitation goals in place compared to a national average of 95%.
- Therapy teams used outcome measures that were based around individual patient led goals. Therapists completed assessments at the beginning and end of interventions and treatment. Teams measured patient progress over the six-week period and a patient questionnaire was given to patients to complete to measure how effective they had found the treatment. These patient reported outcome measures (PROMS) were fed back to staff and discussed in supervisions. From June to November 2015 the outcome measures to individual services were as follows: for the bone service they were 91.9% (20 responses), nutrition and dietetics 87% (53 responses), speech and language therapy 66.4% (104 responses), community physiotherapy 65.5% (77responses) stroke rehabilitation service 61.8% (99 responses). The higher the percentage score the more positive the outcome.
- Therapy managers told us they were "equivalent or better" when benchmarked nationally through the national intermediate care audit. We looked at the audit results for 2015 and saw, for example 93% of patients reported staff had all the necessary information about their condition or illness prior to seeing them (89% nationally). Eighty nine percent of people reported they had been involved in setting goals (83% nationally) and 86% reported being involved in decisions about their care (81% nationally). Learning from the intermediate care audit included improved access for rehabilitation patients with a triage process at the point of referral and booking of appointments within 24 hours of receiving a referral. Other learning included the development of patient centred care plans to improve patient participation in this process.
- The tissue viability service told us the prevention and management of pressure ulcers was regularly audited. The 'essence of care pressure ulcer care audit' for Q3 & Q4 2014-15 was published in June 2015 and contained the results across the district nursing and the Magnolia inpatient unit. It compared results to similar audits undertaken in previous years and showed a decrease in numbers of pressure ulcers needing treatment. The August pressure ulcer forum noted each team had been requested to bring their Implementation plan in response to the audit to the meeting in September and present this to the group. This formed part of a 'benchmarking activity' where teams could share and learn from each other.
- The diabetic service key performance indicator monitored the number and results of the haemoglobin A1c (HbA1c) testing. This showed more tests were taking place and a clinical improvement for the patients.
- The lymphoedema service used a patient self-assessment completed six months after the initial assessment to monitor outcomes. Questions included topics such as whether the patient felt more able to manage their condition. We saw the figures were 100% positive for the previous month. Clinical outcomes included a reduction in cellulitis episodes and improved skin condition. The key performance indicator was a reduction in hospital admissions.
- District nursing teams reported on key performance data every quarter. These included the incidence of pressure ulcers and numbers of patients receiving support with continence and palliative care.

Competent staff

- All staff we spoke with at all levels within the adult community teams told us they received regular supervision, good support from their manager and had an annual appraisal. Appraisal rates provided by the trust showed the overall appraisal rate for adult community health services was 84.2%.
- Therapy staff said that the appraisal had supported them to develop their careers and identify training. They had good personal development plans
- District nurses had monthly one to one supervision and a record was available. Staff could access clinical supervision groups. There was a preceptorship programme for all new band five staff. There were district nurse meetings with band six and band seven staff every six to eight weeks and there were quarterly

meetings for all staff. Teams all had a link nurse would be responsible for attending meetings with specialists and disseminating new practice to the team. The model was designed to enhance communication and keep teams abreast of trust and national policies.

- The development of band five staff nursing staff was encouraged through secondment as a band six to another team. This provided an additional incentive for staff to join the trust. Over the past two years there had been increasing numbers of staff completing community specialist practitioner training. Staff who had undertaken the band six secondment were positive about the opportunity for professional development. Band three staff were encouraged to attend in-house training in such areas as palliative care and diabetes.
- Nursing staff had a competency folder based around the knowledge and skills framework. All new staff reviewed their competency against this and identified areas for development. A senior nurse assessed these areas and signed them off when they were competent. Out of hours district nurses said they had good access to training both face-to-face and e learning. It was possible to plan for training and this was included in the rota.
- The heart failure specialist had supervision with the consultant cardiologist and one to one management supervision with their manager.
- Band five therapy staff had formal supervision every two weeks and more senior staff every six weeks. Administration staff had supervision every six weeks. Staff told us they could seek advice and support at any time. Physiotherapy managers also held a "surgery" staff could attend. Therapists said the department had a regular in-service training programme. On a monthly basis a 90 minute session was planned that focused on a specific clinical area.
- All staff in all teams told us they had good access to training. Therapy managers told us training was supported including time off and funding for specialist training. Requests for specialist training were considered by a central training panel. Managers told us they had received support for staff training applications for attendance at conferences and study days. They said the trust supported training and allied health professional staff had access to all the training they required.
- Staff received a corporate induction, which on the first day included a trust welcome by the chief executive or executive director, information about the trust (including information governance and e-rostering) and dementia awareness. The other days covered mandatory training for all staff and included topics such as health and safety, fire safety, emergency planning awareness, equality and diversity. Following the trust induction all nursing staff had had a two week local induction to assess basic competencies and therapy staff shadowed experienced therapists for the first few weeks after the trust induction. Therapy staff who had recently attended the trust induction programme told us they thought the training was balanced and not mental health focussed.
- A service manager told us there was good support from the human resource department in managing staff performance.

Multi-disciplinary working and coordinated care pathways

- Referrals for district nurses, community matrons and the intermediate care team went through the single point of access. The single point of access had made joint working a lot easier, had helped to avoid duplication, improved communication and was clearer for the patient.
- The single point of access would identify patients with very complex needs. Where a number of different professionals were involved in caring for one patient a 'risk stratification meeting' would take place. The meetings took place in GP surgeries. The meeting ensured the input was co-ordinated and was intended to improve outcomes for patients and avoid duplication. The meetings were chaired by community matrons and promoted integrated working. We observed a meeting and saw an action plan was developed for each patient.
- There were two intermediate care teams and both were separate from district nurses and community matrons. They were multi-disciplinary teams that included occupational therapists, physiotherapists, band six nurses and community psychiatric nurse support. Interventions would usually be for six weeks and referrals were predominantly post hospital discharge or patients at risk of hospital admission. The team was not fully integrated with social services but this was planned for April 2016. There were good links with social services reablement teams. The professionals in the works worked together effectively. The team had both therapy and nurse managers to ensure professionals had clinical support.

Good

Are services effective?

- Palliative care was commissioned from the local hospice. District nurses also provided care and worked closely with hospice specialists who provided guidance. Joint visits were undertaken when required. The palliative care team had an on-call service and there were good pathways and coordination of care. All six district nursing teams had syringe drivers. District nurses and the care home assessment team told us there was a very positive relationship with the palliative care service and the arrangement worked well.
- We observed a handover meeting with a district nursing team. There was patient centred discussion, planning, and evidence of care planning happening with the patient and working with carers. We saw the team was responsive to patients' requests and considered ways to reduce patient risk. The team promoted continuity by allocating the same nurse to patients. The team told us the benefits they felt of working closely with social services.
- The district nursing team used the expertise of specialist practitioners such as tissue viability nurses and joint visits could be undertaken.
- Staff from bone health services were attending community meetings with social services, GPs and community matrons to try to reduce hospital admissions through falls.
- We spoke with the manager of a care home who told us there was good communication with the district nursing team. The home obtained equipment through the district nursing team who assessed within one week and checked equipment was in use. The district nursing team supported the home with some basic training and the home reported good links with the care home assessment team (CHAT).
- The Care Home Assessment Team (CHAT) worked in care homes to identify and manage health problems in elderly residents at an early stage to prevent the need for acute care. The team had close links with other key community services such as dietetics, physiotherapy and podiatry.
- District nurses said that communication with a few GPs could improve. Some GPs did not invite district nurses to meetings and sometimes teams did not have a direct number to contact the doctor. This meant they sometimes waited 10-15 minutes on the phone trying to get through to a receptionist.
- The continence team were aware of the need to develop pathways between primary and secondary care services. They had made links with services such as the spinal injury unit and had good relationships with GPs. They said more joint work was needed with mental health services.
- A service manager told us of a project funded by the clinical commissioning group for one year where the diabetes team were working with GPs and nurse specialists sat in on consultation sessions to develop GP skills.
- The district nurse out of hours team told us there was good support from the out of hours doctors' service.
- The stroke rehabilitation team worked closely with charities and the social services reablement team. The assistant manager of the reablement team joined weekly therapy team meetings.

Referral, transfer, discharge and transition

- Information from the community services dashboard showed district nurses and out of hour's nurses had 100% response to urgent referrals within four hours and 100% response to other referrals within 48 hours.
- The continence service met its target of seeing more than 75% of patients within three weeks of the initial referral in April, May, June, October, November and December 2014 but not in the other months up to March 2015. The reason for the patients not being seen in 2015 was due to a nurse on maternity leave and a recruitment process was underway to address this.
- The wheelchair service saw 100% of referrals for assessment within 13 weeks.
- Community physiotherapists achieved the target of seeing 90% urgent referrals within five working days in all but two months over this period. The target of seeing 90% routine referrals within eight weeks was only met in April and May 2014. In other months the response ranged from 81% to 87%. The musculo-skeletal physiotherapy target of 90% patients having their first appointment within 13 weeks was not met and ranged from 44% to 75% over the 12-month period. Action was being taken to try to address this through consultation with commissioners, use of agency staff to cover maternity leave and new staff appointed to a vacancy.
- The community stroke rehabilitation service met its target of assessing 80% of patients within three working days in April, May and June 2014 and January February and March 2015. In the other months, it was 67%.
- Community therapy managers told us the team triaged patient referrals daily and contacted patients by

telephone to discuss the referral. There were no occupational therapists in the community therapy teams because social services managed this service. If referral to occupational therapy was considered appropriate, the person may be advised to self-refer or the physiotherapist made the referral.

- Did not attend (DNA) rates had been very high in dietetic services at above 30%. Action had been taken to try to improve this and did not attend rates were around 10%.
- The tissue viability team had an open referral process from GPs, district nurses and consultants. GP referrals did not always provide adequate information and this meant time was spent obtaining additional details.
- District nurses felt acute hospitals gave patients unrealistic expectations on what the district nursing service could achieve. The team were trying to address this problem with meetings between the clinical commissioning group, acute hospitals and community services. We saw a booklet giving comprehensive information about the district nursing service. District nursing case managers had a two weekly hospital strategic discharge meeting with acute services discharge coordinators. If a proposed discharge was particularly complex and equipment required a senior district nurse attended a case conference. A discharge date was negotiated at the conference to achieve a safe and smooth discharge.
- The community continence service told us referrals to other teams such as district nursing and community therapy were usually "smooth". They reported good links with the intermediate care team and community matrons. There were clinical pathways in place but no referral pathways at the time of the inspection but the team said these were being developed.

Access to information

- District nurses told us there had been some teething problems with the electronic patient information system especially around the discharging of patients. Being unable to input notes remotely to the electronic system was a challenge that resulted in a duplication of paper and electronic records.
- District nurse care plans were held on the electronic patient information system and a hard copy kept in the person's home. A district nurse manager said the service was working towards hand held mobile devices and were "almost there" with a pilot of hand held devices across teams planned.
- Therapists entered notes into the patient information system. Patient notes were not kept in the person's home but on a home visit we saw specific guidelines for the management of the patient's condition were available.
- A senior manager described technology as a key challenge. There had been a trust strategy to provide staff with the best information technology systems available. Unfortunately, the trust had experienced problems with this.
- Therapists told us the team had a small office and had to 'hot desk' but reported that whilst the stroke team had enough desks to access the computers, there were often not enough desks for the therapy team. Members of these teams often asked if they could use computer terminals in the stroke team office.
- Community matrons told us the team had frequently experienced problems with mobile telephones. Initially they team reported all incidents but this could reach 16 or more incidents in one day. An audit had been undertaken and the manager planned to escalate this. Community matrons discussed the installation of a landline as part of an action plan to resolve the problem.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The assistant director confirmed adult community health staff had access to guidance produced by the trust and undertook Mental Capacity Act training. This training was not mandatory and data on numbers of staff who had completed the training was not available. District nurses had been trained by practice development nurses. Nurses used a mini assessment with four questions to undertake a brief assessment. If there were concerns about a person's capacity to make an informed decision the person would be referred to their GP. They would also discuss the case with their manager. Arrangements for a best interest meeting were made if required.
- We asked a district nurse about lasting power of attorney and they explained they would usually only need to see this if a best interest meeting had been arranged to make major clinical or accommodation decisions. This would usually be organised by the lead clinician or social worker.

Good

Are services effective?

- Therapists told us a small number of patients may not have capacity and in this case a best interest decision would need to be made. The speech and language therapy service had produced a quick guide on the Mental Capacity Act and shared knowledge with colleagues.
- Staff were observed asking for consent prior to offering treatment. For example, the tissue viability nurse explained the procedure to the patient and checked the patient's understanding of this. On a visit with the district nurse we saw the patient signed to give consent to the photographs being taken.
- When looking at records at the lymphoedema clinic we saw an incorrect consent form had been used. Two different consent forms had been used in different patient notes. We spoke to a member of the lymphoedema team about this and they explained one of the forms was an older form. They also agreed the consent to photographs form should be a separate document to clarify what patients were consenting to and demonstrate there had been a full explanation of the possible use of photographs for training purposes. Following our conversation we were told the consent form had been amended.

Good

Are services caring?

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

We rated caring as **good** because:

- We saw patients treated respectfully and compassionately. We saw a caring person centred approach to care and treatment.
- Patients were involved in their care and staff told patients about the treatment they were offering.
- Staff were aware of the importance of emotional support to the patient and their family.

Detailed findings

Compassionate care

- We attended a number of clinics and home visits and in all cases observed patients treated with dignity and respect.
- We received positive feedback from patients and their carers about the care they received from staff working across the services.

Understanding and involvement of patients and those close to them

- We joined a cardiac clinic and saw action plans formulated with the patient and advice given both verbally and in written form. We saw patients' family members involved in the planning of care.
- At the lymphoedema clinic we saw the nurse gave a full explanation of treatment to the patient, discussed and agreed treatment and set patient led goals. They gave the patient leaflets to support advice given.
- The patient told us they had telephoned for advice "over the years" and had no problems contacting the service and had been seen "promptly" when they had requested an appointment.
- On a home visit with a district nurse we saw the patient had a good understanding of their condition and was able to discuss previous treatments and contribute to the care planning process.
- At the district nurse handover meeting we observed patient centred discussion and evidence of care planning happening with the patient and work with carers.
- We joined tissue viability nurse on a visit to the community in-patient ward. We observed full involvement of the patient in their care and with staff on the ward.
- Self-management of patient's diabetes was encouraged by the diabetes team. When a patient was on the team's caseload they could telephone for support. The service leaflet noted friends or partners could attend interactive education classes. Sometimes family members acted as interpreters in these sessions. Patients could refer themselves to the education classes.
- On a home visit with a therapist we saw patient goals were agreed and discussed with the patient and recorded in their management plan. The therapist told us follow up visits were very individual to each patient. Therapists undertook goal setting with the patient and reviewed these regularly. They said they worked closely with patients relatives.

Emotional support

- The district nurse out of hours team told us they worked with the whole family taking an holistic approach and provided emotional support to the patient and family.
- We attended a home visit for a palliative care patient and saw the nurse provided support to the patient and their family.
- We saw a cardiac nurse worked holistically with their patient and offered to write to the local authority to support the patient's application for alternative housing due to their condition.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The trust had developed services in response to patient need. For example the care home assessment team (CHAT) to reduce acute hospital and accident and emergency admissions. A new crisis response team was planned for the intermediate care service.
- We saw staff respecting the diverse need of the local population. For example, teams arranged visiting times to accommodate religious practice.
- Teams accommodated particular needs of vulnerable people. For example a district nursing team had responded to the wish of a patient, who had been assessed as requiring admission to a care home and supported them to stay in their own home.
- Teams saw patients within the timescales expected. For example, the stroke team saw new patients within 24 hours and district nurse saw most patients within thirteen weeks of referral. Community therapies saw 61% of patients within the expected six weeks.
- There were a small number of complaints and these were responded to within 25 days. We saw teams learnt from complaints and identified actions when required.

Detailed findings

Planning and delivering services which meet people's needs

- The care home assessment team (CHAT) originally started as a pilot project in four care homes and had been developed in response to identified patient needs particularly increased admissions to hospital. The team was now working with most of the care homes in the borough. The team provided a holistic service and supported staff and people living in care homes. The CHAT team could be flexible around how and what it provided to care homes, for example, training in end of life care. A lot of work of the team had involved end of life care planning and supporting the appropriate use of 'do not attempt resuscitation' decisions. The team worked closely with the palliative care service who were only required when complex end of life symptom control was required.
- The public health dietitian worked closely with social services, voluntary and private sector organisations. They had worked with the North Middlesex hospital on a maternal healthy weight project. They provided supervision of lay people trained in behaviour change who encouraged people to eat more healthy food, lose weight and stop smoking. They were involved in a 'healthy weight group' working with a range of other partners including the local authority, charities, sports development and catering services using NICE guidance to develop a local strategy to reduce obesity. They had also worked with local take always to make food healthier as part of the mayor of London's healthier catering commitment. The dietitians had also trained mothers to give advice to other mothers in the playground on reading and understanding food labels this gave them confidence by having new skills. They went to health fairs to give evidence-based advice to questions asked by people who had just had their health check.
- The intermediate diabetes service consisted of a nurse consultant in diabetes, specialist nurses and administration support. The team had implemented a pilot project in one area to upskill GPs and practice nurses where poor diabetes control was identified. The team offered education, home visits and clinics including forensic wards. The dietetic service offered two sessions a week and one education session a month.
- A crisis response team was a new element of the intermediate care team and planned to start in January 2016.

Equality and diversity

- The trust served an ethnically diverse population across the geographical areas of Barnet, Enfield and Haringey.
- Staff were very responsive to the religious and cultural needs of their patients. For example they made appointments to suit religious practice for example they did not visit Jewish patients on a Friday afternoon. Teams had made links with Jewish and Asian day centres and knew what was available locally so patients could be put in touch with appropriate support services.

Good

Are services responsive to people's needs?

- They were aware that some patients may prefer a staff member of a particular gender.
- Staff could also access interpreting services and information about the trust was available in a number of languages.

Meeting the needs of people in vulnerable circumstances

- District nurses gave examples of providing services that met the needs of vulnerable people. They gave examples of where they went the extra mile to support people to remain in their own homes.
- Some teams such as the diabetic service provided evening clinics that were more accessible for patients at work.
- The dietitian worked with adults living with learning disabilities to understand the importance of eating a healthy diet.

Access to the right care at the right time

- The lymphoedema service was available for any patient of any age. The service level agreement was for palliative care patients to be seen within four to five working but they were usually seen in one to two days. The team saw babies at home and school age children in clinics during holiday time. The team arranged home visits with district nurses where patients could not come to the clinics.
- Intermediate care teams caseloads fluctuated and the two teams worked together to meet the demand. Both teams were meeting their response times but had to work hard to do this. Responses times were four hours or 24-hour response for admission avoidance (according to patient need) and five working days for patients referred for rehabilitation. The service operated 9am to 5pm six days a week. On Sundays there was an on-call service which was predominantly telephone advice but patients could be seen as an emergency if there was an admission response crisis.
- A key performance indicator for community therapies was all patients were to be seen for treatment within eight weeks. Therapy managers told us 61% of patients were seen in this period. Therapy managers reported increased referrals and complexity of patient need but no increase in funding for physiotherapy services. The team continually tried to work more efficiently and effectively. For example they facilitated groups where possible rather than seeing individual patients, undertook telephone reviews and looked at skill mix within the team. There was clarity around appropriate referrals to the service and inappropriate referrals would be signposted to other services.
- The stroke team told us referrals from the hyper-acute stroke unit (HASU) were seen within 24 hours and acute stroke unit (ASU) would be seen within three days. Referrals from GP's or self-referrals were seen in three to six weeks. There was no waiting list. The stroke service felt they were moving in the right direction but identified a gap in the service where patients needed to access a psychologist but could not come to the clinic due to mobility issues.
- The district nursing team provided cover on an informal basis between 8pm and 10pm (there was a district nurse out of hours team who worked from 10pm to 8am) to ensure 24 hour care was available. There were plans to make this "twilight" service a formal arrangement and this was due to go to consultation.
- The district nurse out of hours team covered Enfield and Barnet boroughs which was a large geographical area. They told us they were usually able to respond to a call within one hour. Sometimes this would be a telephone response. When in a person's home they did not answer the telephone and so in this situation there may be a short delay.
- District nurses told us told the trust had reviewed equipment delivery and a priority system was in place that involved triaging by managers. This had improved the effectiveness of equipment delivery. Equipment ordered in the afternoon was delivered in 24-hours but this did not include Sundays and bank holidays.
- District nurses usually allocated visits in two-hour slots and either morning or afternoon. Nurses did not visit residential homes between noon and 2pm. The team allocated the patient the same nurse whenever possible to achieve continuity.
- The tissue viability nurses told us there was no waiting list for the service and patients could be seen within 24 hours if necessary but there was no weekend service.
- The community continence service covered the borough of Enfield and comprised of two staff. There was also a band six specialist continence district nurse. Waiting times were usually three to four weeks and follow up appointments were patient led according to need.
- Waiting lists for speech and language therapy services was a pressing issue. A manager said the team was now

Good

Are services responsive to people's needs?

fully staffed with 2.23 whole time equivalent staff. The clinical commissioning group were fully aware of the situation and were aware the waiting list had reduced with the use of agency staff but even with these staff in post patients still had to wait.

Learning from complaints and concerns

- Complaints procedures and other contact information were provided to patients using the service.
- Data provided by the trust showed there had been 15 formal complaints about adult community health services over the previous 12 months. Two complaints were upheld. Formal complaints had all been responded to within 25 days.
- Where possible staff tried to address complaints immediately.
- The district nursing team were aware of a recent complaint. Learning from the complaint highlighted a need for improved communication with patients about the timings of visits. Another was the need to improve documentation and communication to ensure that issues were escalated as needed and patients were reassured that action would be taken. District nurses we spoke with told us about this incident and were aware of action to be taken.

Good

Are services well-led?

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

Summary

We rated well led as good because:

- Teams had a clear vision for the future of their services.
- There were governance processes in place that were being used to monitor and improve services.
- All staff we spoke with told us there was good local and trust leadership. They received good support and were positive about the new borough management structure.
- There was an open culture and staff felt progress had been made on integrating the Enfield community services with the mental health trust although more work needed to be done.
- Feedback from patients was obtained and this was fed back to teams. District nurses felt this regular feedback had reduced the numbers of complaints to their service.
- Staff told us they felt consulted, involved, and asked to give feedback on service delivery.
- Teams wanted to improve the care they gave to patients and worked with the clinical commissioning group to develop plans and services to achieve this.

Detailed findings

Service vision and strategy

- Staff we spoke with were aware of the trust values and said they resonated with their team's values.
- Teams we spoke with had a vision for their services and consistently spoke about further integration of services.
- The assistant director had worked closely with the commissioners to integrate community services. The plan was to bring the four elements of intermediate care teams, community matrons, social services reablement teams and district nurses together. This was approximately 300 staff. It was hoped co-location could be achieved in 2016 and it was hoped to introduce an integrated services manager
- The assistant director saw the integrated multi-disciplinary team meetings (risk stratification meeting) as a positive step in integration. They had been impressed with how well these worked. They hoped to add consultant psychiatry time to the risk stratification meetings in addition to the consultant geriatrician time already committed. They said a big challenge was to improve the integration of physical and mental health services.
- Therapy managers spoke about the physiotherapy vision for neurological services that involved a monthly multi-disciplinary team meeting between health and social services for complex patients. This was currently a pilot project but it was hoped it would develop into a true multi-disciplinary group with fully integrated working. They told us they were also looking at closer integration with social services and ensuring all staff had necessary skills and competencies.

Governance, risk management and quality measurement

- The trust governance structure operated at three levels. Assurance through the quality and safety committee that reported to the board, scrutiny at borough clinical governance committees and delivery through deep dive meetings that looked in detail at all the information about the services.
- The community services risk register included a number of risks pertinent to adult community services. The risk register showed that a regular review of risks was taking place and actions taken to reduce risk.
- The serious incident group reviewed all incidents monthly. Serious incidents were mainly pressure ulcers. Initially a lot of teaching was required and the tissue viability nurse had set up the pressure ulcer forum to take this forward. The forum reviewed incidents and looked at why necessary care was not delivered.
- Band seven staff from other teams undertook monthly peer review audits. The peer reviews were based around care quality commission key lines of enquiry. The results were entered into the trust's electronic audit software and results fed back to the staff team. Teams saw peer review audits as a learning opportunity.

Leadership of this service

- The trust provided adult community services to the borough of Enfield.

Good

Are services well-led?

- The assistant director who was also responsible for older people's mental health services and adult community service reported to the Enfield clinical director.
- Service managers reported to the assistant director including a service manager responsible for adult community services and another service manager responsible for specialist community services. A service manager was responsible for older people's mental health services.
- There were two district nursing area managers and a long-term conditions manager who managed team leaders.
- All staff we spoke with were very positive about the support they received. They reported accessible and supportive local and trust leadership. Staff told us the chief executive was visible within the organisation. Staff were positive about the new borough management structure. The director of nursing and quality was highly involved and there was a high level of engagement from the trusts executive team. Staff felt valued.
- A manager told us being part of the mental health trust had led to improved management structures and sharing knowledge between services. Annual away days for all managers had been useful and provided opportunity to share information and learn from other managers.
- Staff told us they had good development opportunities within the trust and were supported in their personal development including the completion of master's degrees and management training. This had enabled them to progress through the organisation to more senior levels. The trust had a leadership development programme.

Culture within this service

- Staff had access to the trust fact sheet, explaining how to raise concerns at work.
- Teams reported positive team working and good relationships between teams.
- Staff told us there was still some emphasis on mental health issues but they felt they were becoming part of the whole trust but this was a slow process. They felt there was a lack of understanding of the physical health services within the organisation but noted it had taken time for both elements of the new organisation to understand each other. They told us of the benefits they could see in closer working as this progressed and how they had personally benefitted from their line managers understanding of their services. They were looking at how they could integrate further with mental health colleagues and strengthen their knowledge base.
- Senior staff received 360 degree feedback and there was an open culture for discussing individual performance.
- The trust held an annual award evening for staff nominated for a range of trust awards.
- Therapy managers had an informal staff member of the month award that praised and encouraged team members.
- Staff told us they felt confident to raise concerns and felt there was an open culture within the organisation. Staff were aware of duty of candour and band seven and eight staff received training in being open and transparent.
- A team leader told us many people seen by the team lived in deprived areas and often did not speak or write English. The team did not receive many letters of compliment but patients showed their appreciation for the service received by giving staff small presents such as vegetables grown in the garden. These were very important to the team who logged this and shared across the whole team.

Public engagement

- There was a monthly survey of patients' experience. We saw 'tell us what you think' forms in booklets given to patients. Patient feedback was collated and outcomes were cascaded to staff. District nurses told us they felt patient's giving regular feedback had helped to reduce the numbers of complaints.
- Examples of where individual feedback was used to improve services included flexibility of appointment times with appointments available at the beginning and end of the day and consideration given to the location of clinics depending on the service.
- The diabetes service had a good relationship with local user groups. We saw the Enfield diabetes support group had supported the development of diabetes clinical guidelines.

Staff engagement

- Staff told us they felt consulted, involved, and asked to give feedback on service delivery.

Good

Are services well-led?

- Therapists told us there had been lots of meetings and engagement with staff and managers were fully involved when community services had joined the mental health trust
- A dietitian was working with other local trusts to negotiate an enteral feed tender across all of the organisations. They were the lead for the trust and had valued the opportunity to be involved in this work.
- One team told us managers were proactive and had asked their staff to complete a questionnaire on stress levels in the team. Staff told us managers had encouraged them to be open and honest and had received feedback on the results.
- The care home assessment team said the trust and commissioners had been very supportive of the service and involved the clinical staff in decisions about how the service should develop. Staff said that a model for the service had not been imposed on them; it was a staff led project. The team had felt listened to and had the power to make changes.

Innovation, improvement and sustainability

- The GP integrated multi-disciplinary risk stratification meetings had led to effective multi-disciplinary work to meet the needs of patients with the most complex needs.
- The care home assessment team was providing effective support to people in care homes and helping to reduce acute hospital admissions and visits to accident and emergency departments.
- The diabetes team had developed 'living a healthy life': an education, monitoring and screening programme for adults with learning disabilities. This work was commended in the 2013 diabetes quality in care programme