

Leeds Community Healthcare NHS Trust

RY6

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)
RY6X6	Armley Moor Health Centre	Health Centre	LS12 3HD
RY6X6	Beeston Hill Health Centre	Health Centre	LS11 8LH
RY6X6	Bramley Clinic	Clinic	LS13 3EJ
RY6X6	Meanwood Health Centre	Health Centre	LS6 4JN
RY6X6	Middleton Community Health Centre	Health Centre	LS10 4HT
RY6X6	Morley Health Centre	Health Centre	LS27 9NB
RY6X6	Chapeltown Health Centre	Health Centre	LS7 4BB
RY6X6	Rutland Lodge	Health Centre	LS7 3DR

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 the service	Good	●
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Outstanding	☆
Are services responsive?	Good	●
Are services well-led?	Good	●

Summary of findings

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Summary of findings

Overall summary

We rated adult community services as good overall and caring as outstanding.

- We found that there was good incident reporting and learning from incidents was shared.
- We saw that record keeping was of a good standard and that information was stored securely.
- Staffing issues were acknowledged and mitigating actions put in place.
- Business continuity plans were in place and consistently reviewed.
- There was a good understanding of the duty of candour regulation and major incident policies amongst all levels of staff.
- There was evidence care and treatment was based on current guidance, standards and best practice
- We observed good patient outcomes for example in the significant increase of patients wishes to die at home being facilitated.
- There was participation in external and internal audits and the results of monitoring were used to improve quality of care.
- We observed excellent care being delivered by highly motivated staff.

- Patients were treated with dignity, respect and kindness and were supported in decision making
- People's needs were met through the way the service was organised and delivered.
- Services were planned in line with the needs of the local population offering flexibility, choice and continuity of care.
- The leadership, governance and culture supported the delivery of person centred care and staff were committed to the delivery of high quality patient care.
- Staff felt supported and valued in adult community services; there was an open and transparent culture.
- The vision and values are well developed and encompassed key elements such as compassion, dignity and equality. The vision and the strategy were aligned.

However, the trust should:

- Ensure dementia awareness is incorporated into mandatory training.
- Clarify in safeguarding children training records which level has been attained.
- Continue to monitor environmental issues in community clinics

Summary of findings

Background to the service

Leeds Community Healthcare NHS Trust Adult Services provides a wide range of services for patients aged 16 years and over, whose assessed needs are best met by community based nursing therapy services. The services are provided in people's homes, clinics, GP Practices, and care homes. The trust had organised their services into 13 neighbourhood teams and based them around GP practice populations across Leeds. There are thirteen Neighbourhood Teams which are based around practice populations and deliver services in partnership with Adult Social Care. Intermediate care services are provided within the neighbourhood teams which encompass district nurses, community matrons, adult domiciliary physiotherapy. In addition, specialist community services such as the cardiac team and speech and language therapy are organised on a citywide basis. Examples of specialist community services include the cardiac team and speech and language therapy.

All teams worked in partnership with primary care colleagues and with other community and acute services. Access to the neighbourhood teams is by a single point of access, known as the single point of urgent access (SPUR). The service accepts referrals from professionals in acute or community settings where a patient has a Leeds G.P and need community services.

The SPUR is open from 8am to 6pm. Referrals are screened and directed to the appropriate Neighbourhood Team who provide clinical triage to identify what input is required.

Each Neighbourhood Team patient is assigned a named case manager, such as a social worker, nurse or therapist. The case manager co-ordinates the care on behalf of the team and by doing so reduces the number of referrals between services. This also reduces the patient having to retell their story and aims to provide accessible, patient focused, seamless, and consistent care.

The Neighbourhood Team service operates 24 hours a day. The 13 Neighbourhood Teams work from 0700 to 1800 each day and work in caseload clusters, which cover one or more GP practices within the team area. From 1800-2200 when demand reduces the neighbourhood teams come together to work out of three hubs, each covering four or five of the 13 Neighbourhood Teams. The Neighbourhood Night Nursing service operates from 2130 to 0730.

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Director of Nursing

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including: district nurses, community matron, physiotherapists, pharmacist and an expert by experience a person who had used a service or a carer of someone using a service.

Why we carried out this inspection

We previously inspected Leeds Community Healthcare NHS Trust in November 2014 and overall, the trust was rated as requires improvement. We judged the provider to be requires improvement for safe, and responsive and good for effective, caring, and well led.

This inspection was focussed and considered those areas that required improvement.

Summary of findings

How we carried out this inspection

We carried out an announced follow-up inspection of this trust between 31 January – 2 February 2017 and an unannounced inspection on 15 February 2017. At this inspection, we assessed the leadership and governance arrangements at the trust and inspected the core services that required improvement at the 2014 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 provider and asked other organisations to share what they knew. We held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

We spoke with 17 patients, relatives and carers of people who used the service and all of them commented positively.

Comments included:

- All were consistently positive about the care they had received. They told us that staff were caring and treated them with dignity.

- A patient attending a speech and language appointment told us that the therapist always acted as if they had all the time in the world for her.
- As part of the inspection process we received five comment cards from patient feedback of their experience of using the service and all were positive. One of the cards was from the community podiatry service. The patient commented "everything is very good, friendly staff and clean."

Good practice

We saw areas of outstanding practice which included:

- The development of pharmacy technicians which had supported staff and improved patient compliance.

- A speech and language therapist had developed a choir to improve patient speech and language skills and provide social opportunities.
- There had been research in physiotherapy and wound prevention teams which aimed to change practice when complete.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

- To ensure dementia awareness is incorporated into mandatory training.

Summary of findings

- To clarify in safeguarding children training records which level has been attained.
- To continue to monitor environmental issues in community clinics

Leeds Community Healthcare 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

Summary

We rated safe as good because:

- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.
- Care Plans were used and individualised to meet patient's needs. Record keeping was of a good standard. Records were stored securely in line with data protection procedures.
- Systems were in place to protect patients from abuse and staff were aware of the procedures to follow.
- Good practice in the form of safety 'huddles' was taking place and at weekly staff meetings patient safety was discussed with all staff.
- There was a business continuity plan, which identified keys risks that could affect the provision of care and treatment.
- Staffing issues were acknowledged and timely mitigating action taken.

- However, some staff were unclear about the level of safeguarding children training they needed to complete to undertake their role. This was not defined in the training data we received prior to inspection.

Detailed findings

Safety performance

- The neighbourhood teams collected safety performance information. This was used to monitor measure and analyse patient harm and 'harm free' care. It looked at medication errors as well as the incidence of falls, pressure ulcers and Catheter Acquired Urinary Tract Infections.
- From October 2015 to October 2016 on average, harm free care was 94%. In September 2016, the service achieved 97% harm free care. This was better than the England average of 92%.
- New pressure ulcers accounted for an average of 1.54% of patient harm. The percentage ranged from 3% in February 2016 to 0% in October 2016. This was better than the national average of 5.7%.

Are services safe?

- Catheter related urinary tract infections were an average of 0.17% against those patients who had an indwelling catheter. In October 2016, they reported their highest incidence of 1.9%. The average percent throughout the 12 months was better than the national average of 1%.
- Falls accounted for an average of less than 1% of patient harm. This was similar to the national average of 1%. In patient homes these showed an overall decrease in the reporting period October 2015 to October 2016.
- We saw in each neighbourhood team that quality boards displayed safety performance information.
- Weekly safety huddles and daily handovers had been introduced where patient harm and harm free care was discussed with the multidisciplinary team.
- Staff we spoke with thought this was a good idea as the safety huddles increased safety awareness, a culture of safety and identified areas of good practice.

Incident reporting, learning and improvement

- There had been no never events reported during the period 01 December 2015 to 30 November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- During the same period 01 December 2015 to 30 November 2016, there were 1,469 incidents reported. Eighty-three of the incidents were classified as serious and required investigation. Of these, 81 (98%) incidents were pressure ulcers and two related to slips, trips and falls.
- We saw that apart from a spike in incidents of pressure ulcers and falls in November 2016, figures showed a pattern of consistent reduction.
- We saw that there had been work streams developed in the prevention and treatment of pressure ulcers with a wound prevention team and management service which linked into the local NHS acute trust.
- A community falls team addressed the increased reports of falls within the community setting.
- During the inspection, we received examples of root cause analysis, serious incident investigations from the neighbourhood teams. A root cause analysis (RCA) investigation is a method of problem solving that tries to identify the root cause of an incident. When incidents do happen, it is important lessons be learnt to try to prevent the same incident occurring again.
- We saw that the RCA's we reviewed were of a good quality and included further actions and identified staff to complete those actions.
- Staff were encouraged to report incidents using an electronic reporting system. The staff members we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents, including near misses.
- Staff told us that where appropriate, they had received feedback from incidents. For example there had been a patient in podiatry where an infected toe on a diabetic patient had not been recognised we saw that learning had taken place from this. This had been shared at team meetings and a clinical teaching session.
- Lessons learnt from incidents were shared in several ways including, face-to-face at daily team handover meetings, safety briefs, the Community Health Matters quarterly news, and the weekly Community Talk email which was sent to all staff.
- We were told that the service had a monthly neighbourhood clinical Quality Leads review meeting where incidents and all quality data was discussed and reviewed and clinical pathway leads, neighbourhood clinical quality leads attended with a quarterly meeting being joined by matrons. This helped to ensure learning and information was communicated to staff in the neighbourhood teams in a timely way.
- We heard how there had been an increase in incidents relating to insulin administration. As a result staff received briefing training sessions from the medicines management team. The follow up action was that staff who administered patients' insulin confirmed when those patients had routinely received it. Staff were contacted if they failed to let their base know that the insulin had been given. Staff we spoke with in the Beeston neighbourhood team confirmed this had improved practice and there had been a reduction in incidents.

Duty of Candour

- The duty of candour (DOC) is a regulatory duty that relates to openness and transparency. It requires

Are services safe?

providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- The trust had a being open and duty of candour policy and procedure. They described the expectations and actions required for all staff in relation to the DOC requirements. Staff were aware of their duty, what it meant and all staff we asked could describe a situation where it had been applied.
- We saw examples of where DOC had been applied. One of the examples related to a pressure ulcer. A verbal and written apology was given to the person and the outcome included a letter of apology with details of the investigative findings. This showed the trust were open and transparent when things went wrong or not according to plan.

Safeguarding

- Staff we spoke with knew who to approach for advice .This included managers and the safeguarding adults and children's teams. There was accessible information on the trust intranet.
- Staff were aware of how to identify potential abuse and report safeguarding concerns, including whistleblowing. Electronic 'flags' were used on the computerised system to alert staff about safeguarding concerns.
- Staff we spoke with were aware that any patients between sixteen and eighteen years would still be subject to safeguarding children policies and procedures.
- Staff we spoke with understood that a patient's poor health could be stressful for the whole family and affect the welfare of children.
- Staff told us they had completed safeguarding training. The trust target for this training was 90%. Training records showed 90% and 91% compliance in December 2016 for staff across the teams who had completed safeguarding adults and children's training respectively.
- Although there was trust guidance on the level of safeguarding children training required which followed national guidance, the figures for the level safeguarding children training completed was not clear in the information we received prior to inspection. We spoke

with three members of staff who were unsure which level they should complete. We saw the Trust's guidance on the level of safeguarding children training required which followed national guidance.

- We saw that there were sessions set up following the monthly quality meeting to ensure senior staff knew of the process to raise safeguarding adult alerts in order to support their staff.
- We did not see that PREVENT training which gave staff knowledge in order to recognise radicalisation was included in the mandatory training grid although we spoke with three staff who remember receiving information.
- Staff understood their role in relation to the statutory reporting of female genital mutilation. We spoke with two district nurses who showed us the policy on the trust intranet.
- Staff were able to provide examples of feedback from safeguarding concerns and learning. For example, the requirement for external reporting of category three pressure ulcers. We saw that this process had been followed from the incident report process.
- Data for the period from 24 November 2015 to 25 November 2016. During this time, they had submitted 86 adult safeguarding referrals and eight child safeguarding referrals.
- The TB team had submitted 3 children's safeguarding referrals, the podiatry team 1, and neighbourhood teams 2 in this time period. The remaining 2 were submitted from sexual health services.
- The adult safeguarding referrals were across the neighbourhood teams. There was no information as to the nature of these.
- There was a serious case review ongoing commissioned by the local children's safeguarding board. It was not known at the time of inspection whether any young people were involved or adult lifestyle issues were a factor in the harm involved.

Medicines

- The organisation had a medicines management team and seven community pharmacy technicians (6.8 WTE staff which included a manager) working within the neighbourhood teams.
- The technicians received referrals directly and visited people in their own homes to help them understand and be compliant with their medicines. This may be

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following admission to hospital, or following concerns raised by a member of the clinical team. This included referrals from GPs. For example, when a patient who was housebound and needed a medicines review, the technician was asked to carry out the task.

- The pharmacy technicians provided a transcribing service. This was designed to improve safety in transcription and administration of medicines. A benefit of this service is also that it has released nursing time. They worked with GPs, community pharmacies, and others to consolidate medicines administration, educate patients and their carers, and reduce transcribing errors by providing clear and correct information on patient's medication administration records.
- There had been a number of insulin errors within the neighbourhood teams which included missed doses. There were approximately 200 patients who needed at least daily support each day over the neighbourhood teams and there had been 20 drug errors in administration in the last quarter. We saw that the Medicines Management Team were completing further support and training. Themes had been identified from incidents and an action plan was being developed in response.
- There were systems in place to inform staff of those patients who required insulin when the patient lists were drawn up.
- We saw prescription pads were stored securely. We saw that there was a policy for this and there was a prescription form security newsletter for community staff. We saw that prescription pads were not left in staff cars.
- We saw controlled drugs appropriately stored in a care home and the correct documentation completed by the community nursing staff.
- Leeds Community Healthcare NHS trust had a controlled drugs policy dated October 2016. The policy had a review date of October 2019.
- Staff told us they worked closely with local pharmacies to ensure there were adequate stocks of appropriate medicines for end of life care. The drugs were available when needed both during the day and out of hours.
- The neighbourhood palliative care lead we spoke with was up to date with their nurse prescribing and we were informed that updates in prescribing were provided by the medicines management team. We did not see prescribing updates in the training data.

- We saw where appropriate, patients had syringe drivers which delivered measured doses of drugs at pre-set times. All qualified nursing staff that used the syringe drivers were trained in their use.
- The medicines management team had a medicines management page on the trust intranet and a monthly 'medicines matters' newsletter. The newsletter for April 2016 identified there had been three medicines related incidents between January and March 2016. There had been confusion between milligrams (mg) and millilitres (ml). The newsletter provided clarification and informed staff of medication training dates. The training included calculating drug doses, patient safety and administration of medicines, prescribing and safe handling of medicines.
- Registered staff accessed medicines management training as part of their induction and thereafter by clinical updates. Non registered staff had one to one training and completed set competencies.

Environment and equipment

- Safety testing of electrical equipment was taking place and the trust had a safety testing programme.' This was part of an annual planned preventative maintenance (PPM) task undertaken by the estates contractor on all buildings owned by the trust. The most recent testing took place at the end of 2016.
- Buildings not owned by the trust had their safety testing of electrical equipment carried out as part of their maintenance programme.
- Three portable electrical equipment testing "catch up" clinics were held for the community staff.
- We were provided with a list of the equipment's service checks and noted the musculoskeletal (MSK) checks were carried out in February 2016 and due to be checked later in the month (February 2017).
- We saw that there was up to date annual calibration of equipment such as scales and blood pressure monitors. Stickers were in place to show the next date these were due.
- All the clinic locations we visited were well maintained and equipped to provide care and treatment to patients. For example, the speech and language therapy (SALT) clinic.
- The majority of staff said that equipment was available for patients care. There were equipment stores and staff

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were able to request and obtain further equipment in a timely way. They confirmed that patients on the end of life pathway would quickly have the equipment they required which included weekends.

- The out of hours' nursing team staff told us they were able to access equipment for patients, particularly those receiving palliative care when needed.
- Staff who held clinics in GP premises told us they knew where the resuscitation equipment was located in the event of an emergency although the responsibility for the checking of these was that of surgery staff.

Quality of records

- Annual record audits took place and we inspected a sample of 12 audit results from across the teams. The audits took place from March to December 2016. The score for the quality of recording ranged from 72% to 100% against standards of collecting family information and communication requirements. There was a shortfall in some services documenting patient communication needs such as interpreters and literacy problems .However speech and language therapy (SALT) and muscular skeletal (MSK) scored 100% .The results were fed back to the managers for their action. Action plans and review dates were part of the audit tool which were completed appropriately.
- We reviewed ten patient records. These were comprehensive, up to date and there was a good standard of record keeping in line with professional guidance. When not in use records were kept safe in line with data protection principles.
- Between 75% and 100% of staff had received information governance training on the 1 December 2016. This meant that staff who had attended training knew how to keep information safe.

Cleanliness, infection control and hygiene

- We attended home visits, clinics and a care home. In all settings staff used techniques to prevent spread of infection including hand-washing, use of antibacterial hand gel and use of personal protective equipment such as gloves and aprons.
- Nursing staff disposed of infected clinical waste in identified bins which were collected from the patient's home. We observed diligent infection control practice in the nursing care of a patient who had a syringe driver in place.

- We saw that there were environmental audits in place. The results varied across clinics and that some buildings required maintenance and a higher standard of daily cleaning. We saw that there were actions to address these. We saw an example where a clinic had been reaudited prior to our inspection and there had been improvement.

Mandatory training

- Mandatory training was delivered either face-to-face or by e-learning. It included topics such as, information governance, safeguarding for adults and safeguarding children, Mental Capacity Act (MCA), manual handling, and fire safety.
- On the 1 December 2016, the training compliance for the service was 88% against the trust target of 90%. The service was working towards all their services meeting the trust target for mandatory training by the end of March 2017.
- Community gynaecology was the only team to achieve 100% for all of their mandatory training courses.
- Ten of the teams achieved between 84% and 89% compliance against the trust target of 90%.
- The intravenous antibiotic service was the only service that did not achieve the trusts 90% target for information governance training. They scored 86%.

Assessing and responding to patient risk

- Each person accessing services had a holistic health needs assessment/care plan at their first contact with trust staff .This was recorded electronically and formed part of the Leeds care record. Staff we spoke with were clear about the process of dealing with a patient whose condition had deteriorated. We saw there was a procedure for escalation. This depended on the level of the problem but varied from seeking advice from the patients G.P or facilitating immediate admission to hospital.
- We saw that there was a robust assessment of pressure areas which included standardized photography which was uploaded onto the electronic system.
- A manager described the processes that were in place to ensure that staff knew about safety alerts. This involved all staff receiving an e-mail about the alert and them checking their own equipment and removing any defective or faulty equipment in a timely manner.

Staffing levels and caseload

Are services safe?

- The service used a capacity tool which we saw had been applied appropriately.
- Information provided by the trust showed on the 1 December 2016 there were 912.99 whole time equivalent (WTE) members of staff and 17.23 WTE staff leavers in the previous 12 months.
- There were 9.89 wte nurse vacancies and 12.59 whole time equivalent nursing assistant vacancies. There was active recruitment to the posts by way of attending job fairs in addition to advertising...
- Fifteen of the 27 teams were over their establishment rate of staff and we saw that there was movement between teams to offer a balanced capacity.
- Staffing was reviewed on a daily basis and reported to Neighbourhood Teams via the Quality Board and also reviewed at operational and senior management meetings. Allocation of visits took place on the previous day supporting prediction of staffing needs for the following day.
- Since December 2016 there was a capacity tool used to assess demand and capacity across teams.
- We saw an example of two team's off duty and these showed safe levels of staffing against allocation of visits. We were told there would be a e-rostering process implemented to assist in effective demand and capacity planning.
- Senior clinicians had protected time of one day a month to complete caseload reviews.
- We saw there was team coaching in place which supported local leaders with related issues of staff morale.
- The core service had a staff turnover rate of 2% in the 12 months prior to 1 December 2016.
- Sickness rates varied across the core service ranging from 0% to 16.7%. For example, three teams had a 0% sickness rate and six teams had a sickness rate of more than 10%. We saw that this had been an improvement from the same period the previous year when some teams had a sickness rate of 14%.
- The trust could not easily identify the number of shift filled by agency or bank nurses as only collected whole time equivalent numbers. The trust used regular bank staff that had completed community competencies.

Managing anticipated risks

- The service had a lone working policy, dated March 2015 and a review date of March 2018. Patient risk

assessment took into account the environment in relation to making sure it was safe for staff to visit. We saw completed environmental risk assessments in patient's records. The information included an assessment as to the number of staff that should visit to ensure their safety.

- Staff had personal alarms, high visible vests and those working out of hours were requested to telephone their base to confirm they were safe when they returned to their car at the end of their shift. During the night visit, staff were observed recording their visit on the electronic computerised system and they telephoned their base to report they were safe. Staff told us if they did not telephone their base when they were safe in their car, the duty base staff would contact them.
- We saw the management of a patient with challenging behaviours. Strategies had been put in place which were safe and acceptable to staff and the patient.
- We saw that lone working was an item on the community risk register due to the security risks in some local communities. The trust worked with the local police regarding this.
- There had been a lone working workshop in December 2016 for managers in order to obtain the right information to support their staff.

Major incident awareness and training

- Each community service had a business continuity plan. Examples of these were provided prior to the inspection team and included the following teams: the neurological rehabilitation service, cardiac service, respiratory, musculoskeletal (MSK), tuberculosis (TB), the community intravenous antibiotic service (CIVAS), the speech and swallowing team, diabetes service, community podiatry, community gynaecology, neighbourhood teams, and neighbourhood night nursing service.
- The plan for each area covered, staff shortage, loss of building/premises/work environment, loss of information and communication technology (including telephones), utility failure, severe weather, fuel shortage, and sterile services provider failure
- The business continuity plans were in date and provided a record of when it had been used and the action taken. For example, in June 2016 the podiatry service had a temporary failure of equipment. Records showed the business continuity plan was implemented and the action staff had taken.

Are services effective?

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

Summary

We rated effective as good because:

- There was evidence care and treatment was based on current guidance, standards and best practice
- We observed good patient outcomes for example in the significant increase of patient's wishes to die at home being facilitated.
- There was a local palliative care advice line for patients to access out of hours. .
- There was participation in external and internal audits and the results of monitoring were used to improve quality of care. Patient's pain was monitored and assessed; they received pain relief in a timely manner. Nutrition and hydration was managed effectively.
- The physiotherapist team were starting to use the therapy outcome measures assessment tool.
- There was evidence of good multidisciplinary working taking place which improved the timeliness and quality of communication between professionals.

Detailed findings

Evidence based care and treatment

- We found that policies and guidelines were based on national and local guidelines. These were accessible to staff on the trust internet site.
- We saw that guidelines were developed in consultation with multidisciplinary teams. These included, Clinical Pathway Leads, Medical Directors, Operational Managers and the Director of Nursing and Quality, and Quality and Professional Development Department.
- The sample of guidelines inspected had been approved by the Clinical and Corporate Policies Group, ratified by the Quality Committee and were in date. Examples of guidelines inspected included, 'Making Decisions about Resuscitation (Policy and Guidance)' and the 'Controlled Drugs Policy.'
- The service used 'A guide to Symptom Management in Palliative Care' which was supported by Health Education England and the Yorkshire & Humber Palliative and End of Life Care Group.

Pain relief

- We saw there were comprehensive tools in place to assess and monitor pain. These included those used by community nursing and therapy within neighbourhood teams and by podiatry services. Staff were moving from paper records to electronic. There was a template in use for staff working in areas where the electronic records were in use. We saw that these were being completed appropriately.
- We observed community nurses assessing patients' pain levels and saw that they assessed the type and duration of pain as well as factors that made the pain better or worse. Pain control was a priority for staff involved in end of life care and guidelines for medicines to be used were in place.
- Patients' needs were pre-empted for example anticipatory medication for palliative care patients.
- Patients and families we spoke with told us pain was well managed and staff were quick to respond to requests for additional medicines when pain occurred.
- We saw the effective use of syringe drivers which provided effective pain relief for palliative care patients. We saw that these were changed safely. Staff had received training to undertake this.
- The palliative care staff worked with the hospital staff and listened to the patient's wishes. Staff ensured pain management and care plans were quickly put in place and made the patient as comfortable as possible.
- The Neighbourhood Palliative Care Lead was an independent nurse prescriber and could respond to changes in pain levels quickly. This meant patients were not in pain waiting for medication reviews.

Nutrition and hydration

- We saw all patients had their nutrition and hydration needs assessed as part of the core nursing care plans. There was a referral pathway into the dietician service.
- The speech and language therapy (SALT) team carried out swallowing assessments and where appropriate made modifications to the patient's diet to assist with swallowing.

Are services effective?

- Staff were clear that patients at the end of life should eat and drink as they wished and supported them to do so. We observed clear advice given about this to a relative and member of care staff regarding an end of life patient in a nursing home.
- End of life care patients who required a dietician were treated by a dietician from the local hospice under a service level agreement in order to provide specialist care.
- There had been a significant increase in those end of life care patients achieving their wish to die at home. The use of the electronic palliative care co-ordination system (EPaCCS) identified this data. The data for the previous year was 86% against an agreed target with commissioners of 90%. However, it was felt that 90% was high and benchmarked with other areas at approximately 82%.

Technology and telemedicine

- The majority of teams had transferred onto an electronic patient record system and those teams who were transferring had a mixture of electronic and paper records. Staff told us they were supported through the transition. We were not made aware of any connectivity problems.
- Community teams used 'smart' phones and electronic notebooks. Most staff we spoke with were enthusiastic about the use of and developments in technology in the service. They were able to tell us how this improved patient care and was an effective use of resources. For example, staff told us how when visiting patients with a pressure ulcer they were able to share the information by their smart phone with the wound prevention and management service. This enabled the nurse to obtain up to date information and support in management of the pressure ulcer.
- We saw in minutes of business meetings however that there was some concern that some staff did not use the electronic notebooks as required and managers had been requested to monitor this with a view to retraining staff if needed.
- Every month one team completed a 'deep dive' into a case and presented the findings to the weekly trust quality meeting.
- We were informed by senior staff that there was provision for unplanned calls through the day for example a visit to a patient whose bandages had fallen off.
- We heard individual patient outcomes in a team meeting. These included the management of a patient with a tracheostomy who had a history of frequent admissions to hospital due to anxiety about excess secretions. Staff arranged the provision of a home suction machine which reduced anxiety and admissions to hospital.

Competent staff

- On the 1 December 2016, the appraisal rate for the service was 91%. Each member of staff who had an out of date appraisal had an appraisal arranged within the month. Nine teams had a 100% appraisal rate. The trust target for appraisals was 95%.
- Staff told us as a result of staff feedback, staff had a nominated individual who did their appraisal. The structure of appraisal had changed for the better as everyone had the opportunity to discuss their training needs. They said that although there was limited funding for external courses, staff were encouraged to attend internal training and share good practice.
- Physiotherapy staff were involved in local research with one member of staff studying for a PhD in a relevant area of work which would benefit the service.
- Physiotherapy staff accessed training events from a recognised local independent hospital. They also had monthly in service training sessions.
- Five physiotherapy staff were supported to gain the diploma in injection therapy.
- One senior therapist had completed an acupuncture course the previous year and used this in practice to enhance his skills.

Patient outcomes

- We saw that there had been an action plan in podiatry services which aimed to provide documentation in podiatry patient outcomes. This had been rolled out in June 2016 with associated training. This was adapted from a model used successfully in Sheffield.
- The SALT team used SALT college measures of patient outcomes. This model was adapted to the dietetic teams as a basis for their own disease specific measures.
- We were told that there was a clinical audit being progressed for the measurement of the outcomes of spinal injections. The results were not available at the time of inspection.

Are services effective?

- Six members of the SALT team were on a leadership skills course.
- Staff told us they had a structured induction and worked four weeks supernumerary whereby they attended meetings and shadowed other staff. Staff said they felt supported and had a better understanding of their role.
- We spoke with a new community staff nurse who had just completed her preceptorship programme. She reported that this had been a supportive and constructive process.
- We heard how the community MSK staff did not employ newly qualified staff. This was because this was a specialist area and required competency based training.
- Each neighbourhood team had developed a list of all staff together with their up to date competencies. This ensured staff were kept up to date and patients received a member of staff who was competent to meet their needs.
- Palliative care staff had received specialist training in end of life care and were active in professional networks to share best practice.
- Wound prevention and management specialist nurses had additional competencies. They attended the pressure ulcer review meeting to review pressure ulcer incidents, participate in the development of strategies, and there was an active research project being undertaken.
- We saw that in some areas clinics were nurse led for example in gynaecology.
- We saw that clinical supervision took place across the teams. There was an overall rate of 80% which was above the trust target.

Multi-disciplinary working and coordinated care pathways

- Staff in each neighbourhood team were positive about the integrated teams and told us communication was better between professionals.
- All clinicians operating within the team were working in partnership with the patients GP and primary care colleagues.
- We saw that co-ordinated pathways were consistently evaluated. For example the falls pathway was being reviewed by commissioners with a view to align more closely with the falls team at the local NHS trust.
- We saw that the SALT teams and dietetics provided training to local care homes which was valued by care staff and adult social care.

- We saw that there was multi-disciplinary home visits to avoid hospital admissions.
- Staff within one of the location told us there were good relationships between neurosurgery and orthopaedic services at the local NHS trust and independent providers.
- We heard a conversation between the therapists and the social worker where there was a concern about a patients deteriorating condition. Effective plans were put in place and immediate action was taken. This was an example of multidisciplinary working to meet patient needs in a timely way.
- We saw good liaison between the neighbourhood palliative care lead and the care home staff. We observed the neighbourhood palliative care lead informing care staff of new NICE guidelines on mouth care.
- All staff were positive about the Neighbourhood Palliative Care Lead roles who came into post from October 2015. They told us it was beneficial to have a source of expertise in caring for end of life care patients.
- The palliative care lead was very positive about the relationship with all the local hospitals and hospices. Care planning meetings and discharge information was usually co-ordinated in a timely fashion to meet the needs of patients, their families and the wider care team.

Referral, transfer, discharge and transition

- Patients were referred via SPUR by e-mail to neighbourhood teams. Staff told us that they thought this worked well and stopped patients being missed in the referral process.
- Patient records showed discharge forms / transfer forms were completed and all relevant patient information was passed on to other professionals and patient's GP's.
- Staff from the neighbourhood teams provided out of hours cover. Therefore there was continuity of care and staff were aware of patients' needs and requirements should they require further support out of hours. This included end of life patients and support to their relatives and carers. We saw referral pathways on the electronic system from the local acute NHS trust.

Access to information

- Staff could access policies and procedures on the trust intranet.

Are services effective?

- Electronic notebooks were used in the community and staff had access to the internet. Where paper records were held staff inputted the information onto the electronic record when they were at their neighbourhood base.
- We saw that there was beneficial sharing of information on electronic records. When observing a podiatry appointment there was an immediate response to a query sent by the podiatrist to the patients GP.
- When patients were discharged from hospital access to information was done in a timely way through the electronic record system.
- We heard how referrals from outside the Leeds area could be a potential problem as the service may not be using the same computerised network. In these instances staff told us they would telephone the service to obtain further information.
- We saw that the wound care clinical nurse specialists were developing a training film for staff and had planned an information workshop later in the year.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The overall compliance rate for the Mental Capacity Act 2005 training course across the core service was 85% on the 1 December 2016. This was slightly below the trust target of 90%. From December 2015 to September 2016 the service had consistently reached its mandatory training target of 90% for this training course and the average compliance rate was between 91% and 92%.
- On the 1 December 2016, 599 of the 708 staff eligible were up to date with the training course. Seven teams failed to achieve the trust's 90% training target. The lowest figure for training was 75% which meant that not all staff may have had the knowledge about appropriate consent and the Mental Capacity Act.
- We saw staff had requested patients consent prior to treatment and had completed the consent box in all nine electronic records we inspected.
- Staff were observed explaining treatment plans and obtaining written and verbal consent for treatment
- Staff we spoke with were able to articulate the requirements of the Deprivation of Liberty Safeguards (DoLS). There were no patients at the time of our inspection that had this in place. During the inspection we heard staff arranging meetings to ensure best interest decisions were made in line with legislation.
- Where appropriate do not attempt cardiac pulmonary resuscitation (DNACPR) forms had been completed.



Are services caring?

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

Summary

We rated caring as outstanding because:

- Feedback from all patients, and those close to them was overwhelmingly positive about the way staff treated people. Surveys showed high levels of patient satisfaction.
 - We observed excellent care being delivered by highly motivated staff. Patients said that staff went the extra mile and the care they received exceeded their expectations.
 - Patients were treated with dignity, respect and kindness and were supported in decision-making. Patients felt highly involved in their own care.
 - All staff were sensitive to patients needs and ensured they received care and emotional support to meet those needs.
 - There was a strong person-centred culture. People's individual preferences and needs were always reflected in how care was delivered. We saw that patients were cared for holistically with their religion, ethnicity and personal preferences built into care plans. All staff were fully committed to working in partnership with people and making this a reality for each person.
 - We observed staff caring for relatives and offering emotional support. Staff were aware of the emotional aspects of care for patients living with long term conditions. Patients emotional and social needs were highly valued by staff and embedded in their care and treatment. Staff provided specialist support for patients where this was needed.
 - Patients' independence was promoted during visits from the service. Patients felt they built relationships with staff from the services and could openly discuss their wellbeing during appointments and visits.
- about the care they had received. They told us that staff were caring and treated them with dignity. One patient described the nursing team as 'smashing and who would do anything for you'.
- Six patients who attended the musculoskeletal (MSK) clinic were consistently positive about their care. One of these patients told us they felt very safe in the clinic and that staff could not do enough for them.
 - As part of the inspection process we received five comment cards from patients. All gave positive feedback about their experience of using the services. One of the cards was from the community podiatry service. The patient commented "Everything is very good, friendly staff and clean." A patient from therapy services described the service as "first class" and that he looked forward to his visits.
 - We observed all staff provided excellent compassionate care during our visits. For example to relatives, carers and patients receiving end of life care. Visits were unhurried and gave families the opportunity to share worries and feelings.
 - Staff were seen to be sensitive and discreet when offering personal support.
 - A patient attending a speech and language therapy appointment told us that the therapist always acted as if they had all the time in the world for her. She felt this had been vital to her recovery.
 - One team of staff took chocolates to patients on Christmas day.
 - One patient waiting for a podiatry appointment in a busy clinic told us "you feel like a person when you come here and not just a number".
 - The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed.
 - FFT data specifically for the community adult's services was positive overall. Community services as a whole scored higher than the England average between April and September 2016.
 - We saw that some services had their own patient surveys for example MSK and podiatry which showed high patient satisfaction scores. These showed 95% and 90% positive responses respectively.

Detailed findings

Compassionate care

- We observed that all staff had a passion for their professional roles in patient care and supported the whole family.
- We spoke with 17 patients who used services, both in clinics and home settings. All were consistently positive



Are services caring?

- The promotion of self-care was of particular relevance to the care of patients in community settings. We observed patients' independence being promoted during home visits.

Understanding and involvement of patients and those close to them

- Staff demonstrated excellent communication skills during the examination of patients. Staff gave clear explanations and checked patients' understanding. All patients and family members told us they felt fully involved in their care and treatment plans.
- We saw examples of patients being consulted in their future care plans and involved in their care assessments and planning. We saw this happened with patients who were at end of life, patients who had newly accessed the service and for patients visiting the physiotherapy service.
- Staff discussed care issues with patients and relatives and these were clearly documented in patient's records. We saw evidence that family members had been shown how to carry out mouth care for their loved ones and recognise signs of pain.
- We saw training was available for staff in the verification of patient death and some community nursing staff told us they had received the training. This was for situations where the patient's death was expected, such as patients receiving end of life care. This meant where possible, the member of staff who had been providing care and knew the patient and family verified the patient death.
- Staff understood that patients diagnosis had a significant impact upon their lifestyles including finances. We saw that patients and their families on the

end of care pathway were signposted for advice. Stroke patients could access a service which understood their specific employment needs and where possible helped them back into employment.

Emotional support

- We heard specialist nurses and community nurses speak of the importance of assessing people's emotional needs as a matter of routine when visiting them at home.
- Patients felt they built relationships with staff from the services and could openly discuss their wellbeing during appointments and visits.
- We saw emotional support being offered to an end of life patient and their relative and observed a high level of interpersonal and empathetic skills when talking to the patient and their relatives.
- We saw emotional support given to a bed bound patient during a night visit and this was in addition to addressing the patients care needs. This was because the patient lived alone and had told staff they were lonely. The patient told us that these visits were a "lifeline".
- Healthy lifestyle staff were observed to give non judgemental and caring support to patients who had complex emotional needs and wanted to give up smoking. We saw a patient who had disengaged with the service before and was supported to try the programme again.
- Palliative care nurses had referral pathways into local and national bereavement support networks. We saw that staff continued to support families after their loved ones had passed away. Palliative care staff told us that this would be "as long as it takes".

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:

- People's needs were met through the way the service was organised and delivered.
- Services were planned in line with the needs of the local population offering flexibility, choice and continuity of care.
- Patients, relatives and carers were listened to when they raised a concern and received a timely response. The service logged complaints and there was evidence of learning from complaints in the service.
- Services were responsive to individual needs and included access to interpreting services.
- We saw that staff in clinics were flexible in offering appointments and kept cancellations to a minimum. Where appointments ran late, then patients were informed of the delay.

Detailed findings

Planning and delivering services which meet people's needs

- The needs of the local population were considered in how the community services were planned and delivered. Managers we spoke with described their approach to planning and delivering services that were responsive to the needs of patients. Staff told us they worked with local commissioners of services, the local authority, other providers, GPs, and patients to co-ordinate and integrate pathways of care. Commissioners and relevant stakeholders were involved in planning services to provide continuity of care.
- The community adult services had 13 neighbourhood teams who delivered care and treatment to different geographical areas. The teams were multiprofessional. Examples of services provided included district nursing, intermediate care, community matrons, and domiciliary physiotherapy.
- We saw that the healthy lifestyle service provided individualised care such as smoking cessation help which was flexible to community needs and promoted long term health gains.

- We saw that MSK clinics ran between 7.30am to 6.30pm. These times were arranged in response to a patient survey.
- The planning and delivery of care had been challenged from the silver command status in the local health system in early 2017. This was a period when there had been unprecedented challenges to capacity and patient demand. Appropriate strategies had been applied and were still in place.

Equality and diversity

- On the 1 December 2016 between 83% and 100% of staff in each of the teams had received equality and diversity training.
- Equality and diversity issues were managed appropriately. Staff knew about the trusts translation policy and the need to involve interpreters. We saw a patient who attended a speech and language therapy (SALT) appointment. Although they had come with their relative who spoke English, an interpreter had been arranged. This showed staff took action to address patient inequality when planning and delivering care.
- Interpreters were also accessible by telephone. Staff told us that the interpreting service was reliable. It provided interpreting services over a large range of languages and reflected the diversity of the local population.
- Information was available on the internet when required. Due to the numerous languages spoken in the community information was printed off when needed to ensure it was up to date.
- We saw that MSK staff could access online pain assessment in other languages
- We observed that the community premises we visited and used by patients had good disabled access, with accessible toilet facilities and clear signage which complied with the NHS England Accessible Information Standard.
- We saw that equality data collected by the neighbourhood teams had been improved to inform commissioners and other parties such as general practitioners (GP's). This included the under-representation of men who accessed muscular skeletal services (MSK).

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- Adult community services provided a number of services including end of life care. We observed patients receiving end of life and palliative care were treated as individuals. The care documentation showed that the care planned and provided was individualised in meeting patient needs.
- Community matrons offered long term conditions management, for people with complex physical health problems. This helped to meet their needs in the community setting and care homes, and avoided wherever possible hospital admission.
- A number of patients had disabilities and some were house bound. Neighbourhood team staff gained access to their premises via key safes. These were set up in conjunction with social care.
- We visited two housebound patients with night staff who took great care to ensure safety and comfort.
- We saw that there were pathways in place for patients who lived with dementia and their carers. We observed multi-agency discussion within neighbourhood teams which included social care about supporting a family who required benefits and housing advice when they had given up work to look after their relative.
- Dementia training was offered to staff as a standalone course and was being considered for inclusion in mandatory training for 2017.
- We saw that the healthy lifestyle service offered smoking cessation to those patients in vulnerable circumstances who had associated mental health problems, were pregnant and young people.
- We saw that the tuberculosis team accessed a number of vulnerable families and were able to signpost them into other support networks such as social care.
- There was a local palliative care advice line for patients to access out of hours.
- We saw that leaflets for patients were developed according to need. The tuberculosis community team had devised a visual leaflet with country flags on which alerted patients to seek advice on testing if this was their country of origin.

Access to the right care at the right time

- The Neighbourhood Teams had a rapid function which met the target response time within zero to four hours. This included care for patients who required end of life care and those who required an urgent response.
- Patients who were under palliative continuing care were triaged within 24 hours of referral.
- The trust was in the process of developing and agreeing response times with the local commissioners. They were developing a system to enable them to report on response times by referral type, for example, urgent or routine. This was not a current requirement.
- The trust was proud of the improvements they had made in reducing waiting times since the last inspection. They routinely met the 18-week wait national referral to treatment target times. From May to October 2016, the average waiting times across the musculoskeletal (MSK) and gynaecology services were below the 18-week target.
- However the community neurological team capacity and demand had meant there were risks of patients not being seen in a timely way after discharge from hospital. This was now on the risk register and there was discussions with the commissioners to resolve the issue.
- Managers told us that referrals to the gynaecology service had increased from 50 and 60 referrals per month to 70. To mitigate this and to ensure appointments were within the target for the 18 week wait, the clinic was extended by an hour. The gynaecology waiting time at this time was between 10 and 11 weeks.
- The trust had adopted the same 18-week standard for non-reportable waiting times and routinely met this standard. Less than 3.5% of patients waited more than 18 weeks for any appointment.
- The trust had identified concerns with the waiting times for continence, urology, and colorectal service. For examples, within urology and colorectal services, they had 107 patients who had waited over 18 weeks and 20 of these patients had waited over 26 weeks.
- The service was working with commissioners to increase the capacity within the service to meet patient need. We saw that an action plan was in place to reduce waiting times to a maximum of 18 weeks by the end of the financial year.
- In diabetes (for podiatry) services, 44 patients had waited over 18 weeks for an appointment. Eight of these had waited over 26 weeks with the longest wait been 35

Are services responsive to people's needs?

weeks. The trust had worked with the commissioners. A business case was funded to provide additional podiatry services and reduce waiting times to a maximum of 18-weeks by the end of the financial year.

- In the podiatry service, a business case to fund additional services on a recurrent basis and maintain the waiting times within the 18 weeks had been submitted and awaited approval.
- The MSK service was developing strategies to reduce the did not attend rate which was approximately 11%. This included sending a text and letter a week before the appointment.

Learning from complaints and concerns

- Information on how to make a complaint was available on the trust website and on notice boards in community outpatient services.
- The procedure included the timescales for response, making sure the complainant received an appropriate apology and making sure the staff learned from the incident so that it does not happen again.
- The trust provided examples of lessons learnt following complaints. This included holding learning events and

sharing standard operating procedure with staff to ensure they were aware of how to respond to situations. For example, if they were unable to gain access to a patient's property.

- We spoke with six community nurses and two staff who worked in the MSK service about the trust complaints procedure. They were clear about the complaints process and action they should take if someone wished to complain.
- From 1 December 2015 to 30 November 2016 the community adult service received 113 complaints. Seventy-three per cent of these were either fully or, partially upheld.
- Podiatry service had the highest number of complaints, 19 (53%). They also received the second highest number of compliments out of the teams in this core service, 216.
- The community adults service received 1,300 compliments from 1 December 2015 to the 30 November 2016. The cardiac team received the most compliments with 240, followed by the podiatry service with 216 compliments.
- Between 2015/16 and 2016/17 up to 30 November the health ombudsman have completed six investigations for Leeds Community Healthcare NHS Trust, three of which are open and one case was upheld.

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:

- The leadership, governance and culture supported the delivery of person centred care and staff were committed to the delivery of high quality patient care.
- Staff felt supported and valued in adult community services; there was an open and transparent culture.
- The vision and values are well developed and encompassed key elements such as compassion, dignity and equality. The vision and the strategy were aligned.
- The arrangements for governance and performance management operated effectively. There was consistent review of the governance arrangements, the strategy plans and the information used to monitor performance.
- Staff told us they knew how to raise concerns and they were treated with respect when they did.
- We saw evidence of effective staff engagement. Frontline staff knew who the leaders were and how to access them.

Leadership of this service

- The community health service for adults was well led. There was clear vision for the service which was based upon national and local drivers.
- Staff told us that they felt senior managers had responded well to the recent 'silver command' status in the local health system. Effective strategies had been developed which would remain in place.
- We were told by frontline staff that senior managers were supportive through challenging times. For example the healthy lifestyle service was out for tender which had created uncertainty.
- Risk managers reflected the key areas of concern for frontline and management staff, for example the lone working policy. This meant leaders took their staff safety seriously

Service vision and strategy

- Staff we spoke with told us that they knew of Leeds Community Healthcare's vision and strategy and these were adapted to individual services.
- Service strategies included the promotion of treating patients in the community with amended treatment pathways.
- The palliative care team had a service ambition and strategy. This included plans to expand training for care home staff and continue to build links with national end of life care networks.
- Staff we spoke with understood the vision and strategy of the trust and told us that it was integral to the development of services. We saw that there were seven behaviours which were integral to care pathways and policy.
- We spoke with six community nursing staff, four MSK, one SALT member of staff and two podiatry staff who were aware of the vision and strategy of the trust.

Governance, risk management and quality measurement

- There was a clear governance structure in place and local clinical governance meetings took place. This included information from overall trust governance issues. However, some staff told us that the details of the governance meetings were not shared with frontline staff.
- We saw that there was clear consultation with partner agencies such as the local city council about care provision
- The services risk register was regularly reviewed. We saw that a falls risk reduction policy had been implemented as a result of inclusion on the risk register.

Culture within this service

- Staff told us that they felt well supported by their immediate and senior management team. They said there was an open and honest culture and they would not be afraid to raise concerns. The service had a Freedom to Speak Up guardian. Contact details were seen on staff notice boards in the teams we visited.

Public engagement

Are services well-led?

- We saw the podiatry staff was innovative in receiving feedback from the patients who used their service. They had a picture of a tree on a noticeboard where patients and their relatives could post comments.
- MSK services had a service user group 'membership and involvement group' who considered spinal pathway development and 'did not attend' issues.
- MSK staff had devised patient information leaflets which went to a patient reader group for consultation.
- We saw that services had their own public websites to give information. We were shown the community gynaecology site.
- We saw that the expert patients programme had recently been reviewed and would become self-managed. The programme was planned to be decommissioned at 31/03/17 with a view to re-designing and introducing a new service delivery model as a self-management programme in 2017/18.

Staff engagement

- The Chief Executive Officer (CEO) of the trust had a twitter account which staff could message. Staff reported they had tweeted a message and received a response.
- The trust Chair had been out to all neighbourhood teams and listened to staff opinions. There was a positive report on these visits which was shared with staff.
- The senior leadership team had clinical days when they visited staff teams in the community services.
- Staff reported they had met the CEO during their staff induction, they had recently seen them and the CEO remembered them by name.
- We saw that there was a quarterly group meeting '50 voices' with staff with senior management. This had contributed to production of a professional strategy across services.

- The trust had local innovation awards. The SALT services had been successful awarded a national award.
- The trust produced a weekly service bulletin 'community talk' for staff which included updates on training dates.
- Monthly staff updates and learning events took place across the services and updates took place.

Innovation, improvement and sustainability

- Physiotherapy staff told us that senior therapists saw MSK patients at the initial assessment due to a shortage of general practitioners (GP's). This was undertaken in eight practices. Where required patients were then referred into the main MSK service. This service had been developed by the physiotherapy service with the aim to get patients assessed quicker. The funding of this came from the GP practices.
- The community neurological rehabilitation team had developed a vocational triage tool which aimed to support staff in dealing with patients who faced job losses because of their condition.
- Community pharmacy technicians received referrals from other professionals and visited people in their own homes to help them understand and be compliant with their medication. This was following an admission to hospital or concerns raised by a member of the clinical team.
- We saw that the wound care team undertook research which would be shared on a local and national basis.
- A speech and language therapy team member had developed an award winning choir which helped patients in their speech and language skills and provide social opportunities.
- The development of the pharmacy technicians reduced the time nurses had to spend transcribing medicine charts and optimised patient safety.