Homerton University Hospital NHS Foundation Trust

RQXM1

Community health services for adults

Quality Report

Homerton University Hospital NHS Foundation Trust
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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)
RQXM1	Homerton University Hospital	Community Health Services for Adults	E9 6SR

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

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

Where applicable, we have reported on each core service provided by Homerton University Hospital NHS Foundation Trust and these are brought together to inform our overall judgement of Homerton University Hospital NHS Foundation 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

We found that community health services for adults at Homerton University Hospital NHS Foundation Trust were 'good' in terms of safety, effectiveness, caring, responsiveness and well-led. This was because:

- There was a good overall safety performance across community adults services and effective processes for identifying and managing risks. There were very low levels of reported serious incidents and incidents resulting in harm. Staffing levels, infection prevention and control, medications and completion of mandatory training were overall well managed.
- Practitioners across services demonstrated effective evidence based care and treatment in accordance with national guidelines and good practice. Services measured outcomes using objective and patient reported measures. Staff had good access to training and development. There was good multi-disciplinary working between staff and with external partners.
- Patients reported positive feedback about the care and treatment they received. Staff treated patients in a kind and compassionate manner. Patients and their relatives were encouraged to be partners in their care planning and were enabled to participate in care activities.
- Community adults services had a model of integrated community teams across health and social care to ensure patients received joined up working. Staff were responsive to the needs of different communities and vulnerable patients. Community adults services demonstrated learning from complaints.
- There were appropriate plans in place to develop the community adults service. There were effective governance and reporting structures in place for the escalation of performance and risk information. Senior leaders had a clear understanding of their services, local risks and challenges and realistic plans to develop their services. Staff told us managers were accessible and supportive. Patients were involved in service development. There were some areas of innovation including the introduction of extended scope practitioners.

However:

- Overall compliance with completion of mandatory safeguarding level 2 training (and Mental Capacity Act and Deprivation of Liberty Safeguards training which was incorporated in the same module) needed to improve to meet the trust's local target. The trust was aware of this and had put in place actions to improve training completion.
- The trust's new online appraisal reporting system did not provide sufficiently accurate data to present a complete record of completed staff appraisals. The trust was aware of this and was working to identify those staff who needed to have their appraisal.
- There were separate electronic record systems used in the hospital and community teams. Staff told us this could sometimes lead to problems with effective transfer of information from acute to community practitioners.
- Some of the trust's staff and partners identified a need for greater out of hours community nursing input, which was not provided by the trust.

Summary of findings

Background to the service

Homerton University Hospital NHS Foundation Trust is an integrated care trust in Hackney, East London. The trust provides general health services at hospital and in the community with staff working out of 75 different sites, serving a diverse local population from Hackney, the City of London and surrounding boroughs in East London. The trust employs over 3,500 staff and is governed by a Board of Directors and is advised and supported by a Council of Governors drawn from patients, staff, membership and partner organisations in the local area.

Hackney was ranked the 11th most deprived local authority overall in England in the 2015 Index of Multiple Deprivation. Hackney's population is estimated at more than 263,000 people. Hackney has a relatively young population, with 25% of residents under 20 years old. The proportion of residents between 20 and 29 has grown in the last ten years and now stands at 21%. People aged over 55 make up 18% of the population.

The City of London has a growing population and was judged as the 262nd most deprived local authority out of 326.

The trust provides adult community health services to support people to stay healthy, manage their long term conditions, to avoid hospital admission and following discharge from hospital to support them at home. Services are provided from health centres, clinics and in people's homes.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Nicola Wise, CQC

Inspection manager: Max Geraghty, CQC

The inspection team included CQC inspectors who were accompanied by specialist advisors in community health services; including nurses, therapists and a doctor; and experts by experience.

Why we carried out this inspection

We inspected this provider as part of our comprehensive inspection programme.

How we carried out this inspection

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

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

Before our inspection we reviewed a range of information about the trust and spoke with the local clinical commissioning group and local Healthwatch. We also reviewed feedback from patients and members of the public which was submitted to the CQC. We held eight focus groups for clinical and administrative staff to share their experiences of working at the trust.

As part of the inspection process we spoke with members of the trust's senior leadership team and individual staff of all grades. We observed staff delivering care within the community at clinics, health centres, hospices and in people's homes. We spoke with patients and looked at comments made by patients who used the community health services and reviewed complaints that had been raised in the service.

Summary of findings

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experience of the quality of Homerton University Hospital NHS Foundation Trust adult community services.

Good practice

- The trust's community adults services demonstrated highly effective internal and external multidisciplinary working, facilitated by co-location of services and partnership working with other service providers.
- The trust had extended scope practitioners in physiotherapy. These staff displayed skills beyond the expected level of competency. For example, they carried out interventional injections under patient group directions (PGD) and undertook ultrasound in their clinics. This enabled one stop diagnostic interventions within the community, reducing the need for referrals to hospital-based services.
- The trust worked with staff, patients, patient representatives and members of the local community to establish quality priorities and outcomes within community services. Some community services held patient involvement user groups to facilitate service co-design and seek feedback on improving service provision. Patient-led groups also provided opportunities for patients to share their experiences of managing their conditions with others.
- The trust's practice development nurses provided accessible learning and development support on specific subjects for staff working in the community.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should take further steps to improve compliance with completion of mandatory safeguarding adults level 2 training to ensure all relevant staff have the required knowledge and skills to respond to safeguarding concerns.
- The trust should take further steps to improve the accurate and timely recording of completed staff appraisals to ensure all relevant staff receive a planned, formal annual review of their performance.
- The trust should take steps to improve the timely and accurate sharing of information between acute and community practitioners working on separate computer networks to ensure all pertinent patient information is accessible by the right people at the right time.
- The trust should take steps to improve the Friends and Family Test response rate in community adults services.
- The trust should review demand and investigate options for expanded out of hours community nursing provision.

Homerton University Hospital NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the community adults services as 'good' for safe because:

- There was a good overall safety performance across community adults services and effective processes for identifying and managing risks.
- There were low levels of reported serious incidents and incidents resulting in harm.
- Medication administration, storage and management was discharged effectively and safely.
- All the community locations we visited within the trust were clean and well equipped to provide safe care and treatment to patients.
- There were low levels of staff vacancies and the trust was effectively managing staff turnover and absences within adult community health services.
- There was good overall compliance with completion of mandatory training at 88% for all community adults services, very near to the trust target of 90%.

However:

- Community adults services were not compliant with the trust's target for mandatory safeguarding adults level 2 training. The trust was aware of this and had put in place actions to address it.

Safety performance

- The community adults services had a good overall safety performance in the 12 months before our inspection. Each team within the community adults service routinely reported against key safety performance indicators, including for pressure ulcers, venous thromboembolism (VTE), falls and urinary tract infection from catheterisation (UTI). This information was collated by the trust on a monthly basis and reviewed by the head of nursing and senior staff of relevant divisions. A collated report on safety performance was presented to the trust board each month and the performance data were bench marked against other identified trusts for comparison.
- During our inspection we saw the NHS safety thermometer (local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care) in use by community adult services. In the three

months before our inspection, the trust reported four community acquired grade 3 pressure ulcers, eight grade two pressure ulcers and one deep tissue injury. This represented fewer than 0.5% of all patients receiving treatment in the community, and was lower than the national average for similar trusts in England.

- The trust had effective systems and processes for identifying and managing risks. The two main risks identified in the community adults services related to access to RIO for the Adult Community Nursing Team, where limited access to the electronic records system had resulted in incomplete or inadequate information being recorded; and effective management of the lone worker device by community nurses. There were mitigating actions in place for both of these risks.

Incident reporting, learning and improvement

- Incident report data collated between December 2015 and November 2016 showed 599 reported incidents. 52% of these incidents related to two of the five adult community nursing clusters. 98% of reported incidents were recorded as no or low harm.
- NHS trusts are required to report serious incidents to the national Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported one serious incident relating to community adults services between December 2015 and November 2016. This related to a medication incident. There were no reported never events.
- The trust used an electronic system for reporting incidents. All of the staff we spoke with across adult community services were aware of how to report incidents. Nurses completed online incident forms and these were escalated to managers (band 7 and above). Where required, root cause analysis (RCA) investigations were carried out by the clinical manager nominated to undertake the investigation and the final outcome distributed to those involved..
- Incidents were discussed at weekly 'complaints, litigation, incidents and PALS' (CLIP) meetings which were attended by both hospital and community clinical managers. Managers fed back learning to their teams at team meetings and handovers.
- Staff we spoke with told us they had learnt lessons from reported incidents and discussed examples of incidents to assist learning. For example, staff told us about an incident with insulin administration and as a result changes were implemented to medicines administration and additional training was given to staff.
- We reviewed a sample of reported incidents. Concise descriptions of the incidents were recorded along with identified actions that had been taken. All incidents we reviewed were reported and investigated in a timely way, reviewed at CLIP with investigation and lessons learnt completed.
- On review of the incident database we saw 156 open incidents dated pre-January 2016. 13 of these were in community services. All 13 had lessons learnt completed, and actions completed were specific and followed an agreed sign off process via CLIP. We spoke with the trust's risk manager in regards to the open overdue incidents. We were told that this was an administrative delay and a plan was in place to have all outstanding incidents closed within six months. The trust confirmed that all of the 156 open incidents had been reviewed and closed in the week after our inspection.
- The trust did not have a system for recording incidents specific to end of life care as the service was provided as part of the integrated community service. This made it difficult to identify issues and themes specific to end of life care. However, staff involved with end of life care were able to provide examples of incidents they had raised. For instance, adult community nurses told us they reported all pressure ulcers graded two and above as incidents. A palliative care occupational therapist told us about reporting the failure of equipment.

Duty of Candour

- The trust had a policy called 'Being Open and Duty of Candour', which some staff were familiar with and understood. However, during our visit we found limited awareness of duty of candour amongst some of the staff we spoke with, particularly amongst physiotherapists and occupational therapists. The trust did not include duty of candour in its mandatory training package, but it was incorporated into the trust's corporate induction for new staff. This meant that some staff would be aware of the term and what it means, while other, potentially more established members of staff may not have received the same information. During our inspection an 'all staff' email was sent from the trust's Chief Nurse

to remind staff about the principles and requirements of duty of candour and the trust's policy and processes for reporting incidents and discharging duty of candour responsibilities.

Safeguarding

- Staff we spoke with demonstrated a good understanding of safeguarding principles and processes, and their roles and responsibilities in protecting vulnerable adults. Staff were able to demonstrate they understood the appropriate processes for raising safeguarding concerns. An adult community nurse told us they saw safeguarding as a collaborative process. If they had concerns they would speak to their manager and share information with the relevant GP and the trust safeguarding team. We were given a recent example where a patient had been at risk of pressure ulcers. The staff member raised a safeguarding referral and spoke to their manager about their concerns. The concern was escalated to the head of nursing and relevant information was shared with the GP.
- Adult community nurses received safeguarding training to level two and managers were trained to level three. Managers told us that requirements had recently changed so that band five nurses were now expected to be trained to level two and this was in progress. Level one training was completed at corporate induction and level two was set up as an online learning package, which was competency based. This was supplemented by face to face workshop style sessions conducted by the Safeguarding Adults Team.
- We found inconsistent levels of compliance with completion of mandatory safeguarding training within the trust's adult community services. However, the trust was aware of this and was actively working to improve training compliance rates. The trust set a target of 90% for completion of mandatory safeguarding training. At the time of our inspection the community adults services demonstrated an overall compliance of 97% for safeguarding level one. However there was a low compliance with level two training which was recorded at 57% at the time of our inspection. The percentage uptake of safeguarding training across adult community nursing clusters was 62% for cluster one, 47% for cluster two, 70% for cluster three and 80% for cluster four.
- We met with the trust's interim lead for adult safeguarding who provided assurance that the safeguarding team was working with the trust's learning and development team to identify staff who were not compliant with training. Information submitted by the trust shortly after our inspection confirmed that emails were sent to relevant members of staff and their line managers to remind them to complete the training and the interim lead for adult safeguarding offered to visit teams in the community to give them an update on safeguarding processes. Two weeks after our inspection the overall compliance rate had increased to 72% across all community services teams.
- During our inspection we were made aware of a recent safeguarding adult review (SAR) published by City and Hackney Safeguarding Adults Board. A SAR is a multi-agency review process to determine how agencies or individuals may have acted differently to prevent harm. The SAR identified some shortcomings in community healthcare provision, including those managed by the trust and the management of end of life care. In particular, it highlighted that no one agency took a holistic view regarding end of life care which led to poor communication between agencies, a lack of co-ordination and multidisciplinary working. We were informed by the Safeguarding Adult Board that the trust had fully engaged with the SAR throughout the process, providing details about the case and reflecting on their involvement from the beginning.

Medicines

- We found that medication administration, storage and management was discharged effectively and safely across the trust's community adults services.
- Medicines were stored securely and appropriately across the services we inspected. For example, at the locomotor service at Saint Leonard's Hospital injection medication was secured in locked cupboards within the ultrasonography area. Medication was stored in cupboards within coded locked rooms. All areas containing medication were accessible by swipe card only.
- Training records indicated that relevant nurse prescribers had attended patient group directives (PGDs) and competency based training. There was a set formulary for what they could prescribe, approved by consultant doctors. The trust's pharmacy department

conducted random audits of prescriptions, to check compliance with the trust's policy. Nursing staff working in the community had access to pharmacy support, through the GP surgeries they worked with.

- We saw that the Medication Administration Record (MAR) in patient records was completed correctly for all of the patients we visited. In each patient record we saw, there was a care plan in place and arrangements for 'just in case drugs'. The drugs were documented by the hospice and administered by community nurses. All patients had 'Coordinate My Care' documents in place.
- The community adult teams worked in partnership with other agencies to provide end of life care. Where patients had been referred to the specialist palliative care team at St Joseph's Hospice, 'just in case' drugs and syringe pump medication were arranged by the hospice during the initial assessment or on discharge. They also provided drug chart and drug stock sheets. We saw some patients also had community drug charts and stock sheets, and observed an adult community nurse transcribing on to their local drug chart. We were told by staff that this should be performed with two members of staff present, although on this occasion there was only one.
- The controlled drug midazolam was prescribed to patients receiving end of life care where it was required. This included for continuous subcutaneous infusions (syringe drivers). There were two strength measurements in use. The British National Formulary stated 'the use of high strength midazolam (5 mg/ml in 2 ml and 10 ml ampoules, or 2 mg/ml in 5 ml ampoules) should be considered in palliative care'. Staff needed to be aware of the two strengths of medication so that there was no confusion when making up a syringe driver. This was because both the higher strength and lower strengths, of 1mg in 1ml of midazolam were being prescribed.
- We observed a multidisciplinary meeting coordinating the end of life care for a patient at a GP surgery. An adult community nurse, GP and community nurse specialist from St Joseph's Hospice were in attendance. Monitoring of medication and titration were discussed through a multidisciplinary approach.
- There were some reported challenges with timely out of hours medicines access for end of life care patients. Patients discharged from Homerton University Hospital were provided with controlled drugs and other medication by the hospital pharmacy. However, out of hours access to controlled drugs in the community was arranged through a local pharmacy. Adult community nurses told us when patients receiving end of life care were discharged during evenings or weekends it could be difficult for adult community nurses to get the appropriate medication for use at home. Controlled drugs were available from Homerton University Hospital during the day but not in the evening. During out of hours there was only one pharmacy in the borough that was able to dispense controlled drugs, which made it more difficult to provide end of life patients with timely essential medication. We were informed that commissioners were looking to develop a medicines service and appoint a chemist to stock end of life drugs as well as a courier service to improve the level of provision.

Environment and equipment

- All the community locations we visited within the trust were clean and well equipped to provide care and treatment to patients. This included those sites which were not under the direct control of the trust, for example, community health centres.
- Adult community nurses had sufficient equipment to treat patients in their homes. All use of equipment or dressings were pre-planned in order to ensure availability. Nurses carried back packs with necessary equipment when doing home visits. We were told by staff that sometimes they had to return to base to replenish stock during shift as stock was not left at patients' homes. Staff told us this was sometimes a burden especially when travelling via public transport.
- Service stickers were displayed on the equipment to show that it had been serviced.
- Patients we visited had appropriate equipment in place which was operated correctly by the community nurses. Medical devices used by the community nurses all had asset numbers and were annually serviced. Needle safe equipment was provided where required to reduce occurrence of injury. Single patient use equipment such as disposable tape measures and blood pressure cuffs were not always in use.
- Glucometers were used for the care of diabetic patients and the nurses we visited all had a personal issue glucometer. The meters were checked on a daily basis by the adult community nurses and were calibrated and serviced annually by the trust.

Good

Are services safe?

- Staff reported equipment faults and outstanding equipment needs to the divisional managers. We observed the community nurse specialist (CNS) reporting a faulty light control and following up an order for a hospital bed and mattress with the adult community rehabilitation team.
- The trust was not responsible for arranging repairs and servicing of community equipment, such as hoists. The community equipment provider was commissioned and managed by the local authority to do planned maintenance and servicing on equipment in patients' homes. During one patient visit undertaken by the trust CNS we observed that the patient's hoist was overdue a service. This had been raised by the carer to the adult community nurse but had not been reported. The CNS agreed to action this point, although they said this might have led to a delay in the correct working equipment being in place as the CNS did not visit as regularly as the adult community nurse.
- The palliative care occupational therapist held a small stock of essential equipment at the hospital which could be provided the same day. Additional equipment which was required was arranged through the online equipment ordering service and signed off by the manager.
- We observed a multidisciplinary meeting involved with coordinating the care of end of life patients at a GP surgery. An adult community nurse, GP and a CNS from St Joseph's Hospice were in attendance. The monitoring of patients on syringe drivers took place with requests to bring forward visits from hospice staff for help and advice.

Quality of records

- We saw adult community nurses complete comprehensive records following home visits which indicated what actions had been taken and equipment that had been ordered.
- The trust audited the quality of records. We were told that the most recent audit for community nursing staff records indicated that improvements needed to be made by providing staff with guidance so that information was recorded in a consistent manner.
- Some patients kept records within their home which held key documentation. The records that we looked at contained a care plan, drug chart, progress notes, patient contact notes, Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) document where appropriate and community nursing contact details.
- The Acute COPD Early Response Service (ACERS) had access to hospital and community notes via the electronic patient care record which provided a single care plan for the patient between the hospital and community, wherever care was provided.

Cleanliness, infection control and hygiene

- We observed community practitioners following procedures to reduce the risk of infection in clinics and when visiting patients at home. Hand hygiene was used correctly at suitable points of care and personal protective equipment (PPE) was available and we saw it was used appropriately. One home we attended on a community visit had no hand washing facilities so alcohol gel and gloves were used.
- All treatment rooms we visited were visibly clean and well maintained. Cleaning schedules were in place across the trust's community locations. Medical devices used by community nurses were cleaned appropriately after their use.
- In the clinics we visited we saw cleaning schedules were in place, sharps bins were in use and appropriate PPE was being used. However, when visiting Kenworthy Road Health Centre we saw two large sharps boxes dated 2015. When questioning why they had not been disposed of and changed a staff member told us they had to fill the boxes to the top before disposing. Information submitted by the trust shortly after our inspection confirmed the advice had since been changed and sharps bins were disposed of after three months. In addition, smaller sized sharps bins had been ordered for use in clinic settings.

Mandatory training

- Within adult community services mandatory training took place online and in practical sessions. Reminders were sent out to staff when training was due to be undertaken. We were told by staff and managers that staff were given adequate time to complete their training. The mandatory training package included basic life support, infection prevention and control, manual handling, fire, conflict management, lone working, infection control and safeguarding.

Good

Are services safe?

- As of December 2016 the overall training compliance for this core service was 88%, very near to the trust target of 90%. A 90% target was achieved in eight of the 15 mandatory training modules.
- Of the 22 different units within adult community health services, 21 units were achieving the 90% target in half or more of the modules.
- We spoke with new members of staff who stated the induction programme was informative and the mandatory online training modules were good as they could be completed in their own time around patient lists.

Assessing and responding to patient risk

- We saw senior staff planning home visits to patients and observed that the time and skill mix requirement was considered when prioritising visits to patients.
- We observed staff on home visits regularly undertaking and recording routine assessments, asking patients about bowel movement, eating and drinking, pressure areas and falls. Adult community nurses told us that risk assessments were an ongoing process and they used a joint assessment care plan (with palliative support where needed), which was a bundle that included SSKIN (a five step model for pressure ulcer prevention), nutrition and hydration assessments.
- During one home visit we saw staff responding quickly to a patient who reported soreness from a pressure area. The member of staff made telephone calls to ensure that a nurse from the trust's integrated independence team would assess the patient that day, a pressure cushion was ordered for delivery later the same day and appropriate advice on relieving the soreness was provided.
- During one home visit we observed a CNS ensuring their patient was aware of how to access timely support from the GP for early signs of infection or respiratory difficulties.
- The adult community nurses made their own nursing judgement through communication and observation as to whether a patient's health had deteriorated. Deteriorating patients were also discussed at handover meetings and observations shared.
- Adult community nurses told us they called NHS or 111 emergency services if they found a patient had deteriorated out of hours or on weekends. There was also a 24/7 palliative helpline for staff, together with a service level agreement with local hospices to provide support.
- Tissue viability nurses worked centrally from a clinic in Fountayne Road and Kenworthy Road Health Centres and every three weeks went out with the adult community nursing team on their home visits. The tissue viability nurses had identified a gap in community nurses' knowledge across the trust and were looking into training and upskilling band 5 nurses to be equipped to review wounds.
- At the point of referral for end of life care, senior adult community nurses carried out an initial assessment and agreed with the patients' family or carers the frequency of visits. Visit frequency was based on clinical need, risk and the level of support the family or carer wished to provide themselves. We were told that the adult community nursing service had the capacity to visit a patient twice daily if the need existed. There was also provision of 'night sitter' support through charity organisations such as Marie Curie if this was required.
- We observed a handover within community nursing where palliative care patients were discussed. Full information regarding the patient was provided including actions that had been taken, medication and equipment that were in place. Staff were reminded about patient confidentiality and not to take out any sensitive documentation with them.
- We observed a multidisciplinary meeting which involved the coordination of end of life care for patients at a GP surgery. An adult community nurse, GP and CNS from St Joseph's Hospice were in attendance. There were updates on the care and coordination of individual patients between the three parties. Discussion took place around individual risks to specific patients; those recently discharged from hospital, those deteriorating and changing support given and patients who had recently died.

Staffing levels and caseload

- At the time of our inspection there were low levels of staff vacancies within adult community health services and the trust was effectively managing staff turnover and absences. There was a low overall vacancy rate of

2% across all adult community services. Some services had higher vacancy rates, including the Diabetes Eye Screening team and Locomotor Service with 13% and 9% vacancies respectively.

- Community adults services used bank and agency staff to cover rota gaps when required. Adult community nurses told us that it was sometimes difficult to get suitable agency staff, and on busier days they did not always have enough staff. This was sometimes the case when they received a referral that required an assessment the same day which they had been unable to plan for. However, this was not seen as the norm.
- Some staff told us that although at times they had to work additional hours to respond to urgent situations, they were encouraged to take their hours in lieu.
- Although the trust reported low staff vacancy rates, we heard differences in opinion amongst staff concerning staffing and management of caseloads. One adult community nurse told us the services for end of life care within the community were strong, particularly the number of adult community nurses they had available. Another adult community nurse told us recruitment and retention of staff had been an issue. We were told that sometimes adult community nurses would see between 12 and 14 patients in a day when it should be between eight and ten. This would result in staff sometimes working late to write up notes from their day. Although there was pressure on staff, they said it did not impact upon the care provided to patients. However, it did mean that some nurses had left the service due to not being able to manage their caseloads. Staff said that managers were addressing this through recruitment and by monitoring work through daily diary logs.
- A daily nursing handover was conducted in each location we visited and we witnessed a sample of these at Rushton Street Health Centre and John Scott Health Centre. The handovers we observed were well structured with good communication between staff and all pertinent information was shared. Staff had opportunities to ask questions, seek updates on care plans and request support. All patients had a named nurse. Risks and deteriorating patients were discussed and plans agreed. The nurses supported each other and offered opinions for the treatment of each patient.

Managing anticipated risks

- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather. The service had a winter plan in place. This included community staff having access to cars to maintain staff safety and to support access to patients in all community settings. The plan also included providing telephone access for patients to access specialist services, which would provide advice to patients and staff during adverse weather.
- Community nursing senior managers reported that there were no anticipated risks in terms of seasonal fluctuations in demand and that referrals into the service remained constant throughout the year.
- Planning meetings were held daily in each team across the trust's adult community services to review key issues such as incidents, capacity issues and staffing levels.
- A lone working policy was in place for staff working in the community. Some teams used white boards to record when staff were out and they would be contacted by the team leader at the end of the day to ensure their safety. Community nursing staff had personal safety alarms worn during home visits. The staff we spoke with in all areas were aware of the policy for lone working. Across the trust adult community nurses were issued with mobile phones, which meant they were able to keep in contact with their base and request assistance if necessary.
- Senior managers reported an increase in violence towards community practitioners in the year before our inspection. Managers told us risk assessments for new addresses were now routinely completed. Due to an increase in violence and drug usage in Hackney the risk assessment was evolving in line with new evidence and understanding of the different risks.
- We attended a home visit with the integrated independence team. The nurse told us that they felt safe with the current arrangements and the trust's rapid response team would check their computerised calendar if they did not return to base at the allocated time. We were told that a GPS tracking system was in the process of being ordered to track the whereabouts of staff when on home visits. Staff were instructed to call an emergency telephone number if they were at risk or needed emergency assistance. De-escalation and conflict management was delivered as part of mandatory training.

Good

Are services safe?

- Risk assessments on individual patients were in place. Prior to making a home visit, nurses would check the referral, note any flags for safety concerns and speak to other agencies, such as social services to check for any history on the address and patient.

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.

Summary

We rated the community adults services as 'good' for effective because:

- Practitioners in community adults services demonstrated effective evidence based care and provided treatment in accordance with national guidelines and good practice.
- The trust measured outcomes using objective measures and patient reported measures.
- Staff had good access to training and development and were aware of developments and research within their respective fields. Community Nurse Specialists facilitated specialist learning in different areas.
- Patients' nutrition and hydration needs were managed appropriately.
- There was good access to IT systems and adequate numbers of computers for staff use. The trust was introducing laptops for remote working.
- There was good multi-disciplinary working between staff within the trust and with external partners such as GPs and social workers.
- Staff we spoke with were aware of their responsibilities in relation to the Mental Capacity Act 2005 and could describe how they applied it in their daily work.

However:

- The trust's new online appraisal reporting system did not provide sufficiently accurate data to present a complete record of completed appraisals for the period April 2015 and March 2016. The trust was working to address this.
- There were reported difficulties with transferring Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and treatment escalation plans between the hospital and community services because of different computer systems.
- The trust incorporated Mental Capacity Act and Deprivation of Liberty Safeguards training into mandatory training on Safeguarding adults level 2, for which community adults services were not compliant with the trust's local target for training completion.

Evidence based care and treatment

- The trust's community adults services demonstrated effective evidence based care and treatment. We observed staff following appropriate assessment guidelines when delivering care to patients. We saw copies of relevant documents were available at bases for staff to reference, and staff had access to policies and guidance on the trust's intranet. Staff in the trust's learning disability service demonstrated how to access guidance and pathways on the trust intranet and told us it was straightforward to find the necessary information.
- We found that patients received a full assessment of their individual needs and the records we viewed had been completed to reflect this. Assessments were completed and updated as patients' needs changed.
- Assessment screening that took place included screening for dementia, depression, falls, pain and infection. Appropriate assessments were completed and up to date, including for falls, catheter care, pressure area care and nutritional risk in the care records we looked at.
- Community staff used nationally recognised assessment tools in the assessment packs including the malnutrition universal screening tool (MUST) and Waterlow scores (gives an estimated risk for the development of a pressure sore in a patient). The trust's practice development team was planning to update risk assessment processes.
- We saw standards and best practice were in accordance with National Institute for Health and Care Excellence (NICE) guidelines. Staff we spoke with understood how NICE guidance informed local guidelines.
- We found many examples in practice of evidence based care and treatment during observations of home visits. For instance, an insulin dependent diabetic patient having morning visits after surgery. We found assessment charts completed including a comprehensive initial assessment in notes.
- Comprehensive wound assessments followed best practice (Royal Marsden Clinical Guidelines 2011). The chart used by the trust included size of wound, exudate, surrounding skin, wound bed, infection and pain.

Good

Are services effective?

- Staff in the trust's end of life care team told us they were focused on supporting patients to receive end of life care in the community rather than in hospital and to die in their choice of place. Data provided by the trust indicated that there were approximately 1,100 deaths in hospital each year across the City and Hackney area which the community services covered. There was an aim to reduce the number of end of life care patients dying in hospital. The majority of patients still died in hospital, but there had been a steady decrease over recent years and although it still remained above the England average the gap had closed.
- Staff were aware of developments and research within their respective fields. For example, the trust's Parkinson's Disease CNS was aware of National Institute for Health and Care Excellence (NICE) guidelines in relation to end of life care for adults in the last year of life which were due to be published, and had been liaising with local specialist palliative care services about developing a pathway in line with these.
- The trust's Multiple Sclerosis CNS worked within NICE guidelines related to that speciality. They were also working with nurse consultants at other acute hospitals looking at new models of community working.
- The community palliative occupational therapist was a lead facilitator for the Sage and Thyme foundation level communications based workshop. The model developed by the University Hospital of South Manchester NHS Foundation Trust was designed to train staff in how to deal with patients and carers who were distressed or concerned. It was evidence based, originally developed to meet requirements described in the 2004 NICE guidance on 'Improving Supportive and Palliative Care for Adults with Cancer'. The course was provided to both hospital and community based staff and received positive feedback.

Pain relief

- Pain relief was generally well managed by practitioners working in community adults services. We observed adult community nurses asking patients if they were experiencing any pain, what medications they were using to manage pain, and recording this in the patient records.
- Patients living with chronic long term pain could be referred to the trust's Locomotor Pain Service, which was a specialist MDT community based pain management service for patients living with persistent pain. The team comprised a pain consultant and pain therapy specialists (OT, physiotherapy, and psychologist and pharmacist). This service was available to patients Monday to Friday from 8am to 6pm.
- Practitioners in the Locomotor Pain Service conducted multidisciplinary assessments of patients to assess how pain was impacting on their lives, and to develop agreed treatment plans. Following the assessment the team provided a number of group and individual treatments for patients to manage their pain more effectively.
- Arrangements had been made for patients to have access to anticipatory drugs during their end of life care where appropriate. The drugs were documented by the palliative care team at St Joseph's Hospice and administered by community nurses. This meant that pain could be managed promptly and during out of hours when access to pharmacies was limited.
- We observed a meeting involved with coordinating the end of life care for patients at a GP surgery. An adult community nurse, GPs and a CNS from St Joseph's Hospice attended. Pain relief and symptom management was discussed and monitored through a multidisciplinary approach.

Nutrition and hydration

- Patients' nutrition and hydration needs were managed appropriately. Where a need for additional support with nutrition and hydration was identified, for example with diabetic patients, community and specialist nursing staff referred patients to the trust's dietetics service, which provided practical advice for patients about healthy food choices and worked with patients to change their eating habits.
- During home visits with adult community nurses, we observed the Malnutrition Universal Screening Tool (MUST) being used. Patients were weighed to see if they had any significant changes in weight since the last visit and assessments were made to determine if they were eating well or had any problems with keeping food down.
- On home visits we saw nurses advise patients on fluids and the importance of taking on board water as well as checking on bowel movement.
- The trust's Multiple Sclerosis CNS worked alongside dietitians and speech and language therapists to

optimise patients' nutritional intake. This included discussions about the potential for assisted nutrition and hydration, providing advice to community nurses, visiting patients and contributing to care planning.

Technology and telemedicine

- Across the community adults services there was good access to trust IT systems and adequate numbers of computers for staff use. We saw the utilisation of remote working via laptops by adult community nurses clusters two and three. Managers told us cluster one and four were still waiting for remote working to be rolled out. There was a champion of remote working in one cluster who would help others experiencing difficulties with remote working. The introduction had been a three month staggered launch so staff could get used to it.
- Nurses told us the laptops helped them go through information with patients and they could pull up records with GPs. However, there were some connectivity problems, with 'Wi-Fi dead spots' in parts of Hackney so the trust was investing in a system called 'store and forward' to enable community practitioners to save information even when there was no network connection. Some staff also told us the laptops were heavy to carry, but having trialed computer tablets they had found the laptops worked better so continued to use them.
- Community nurses had remote access to the electronic care record system when visiting patients at home. One nurse we observed was unable to log on to the system whilst visiting a patient. However, we were informed by managers that this was a rare occurrence.

Patient outcomes

- We saw evidence that the trust benchmarked the quality of community services against other similar community trusts and they actively monitored their service performance.
- The trust measured outcomes using objective measures and patient reported measures. For example, senior management told us the locomotor service used a range of outcome measures including: EQ5D, Patient Specific Functional Scale (PSFS), Health Status Questionnaire (HSQ) and the Numerical Rating Scale (NRS). The adult community rehabilitation team (ACRT) used goal attainment scales and a musculoskeletal health questionnaire (MSK-HQ). We were told that there were a number of patients who were managing long term so it was difficult to calculate and measure outcomes effectively in some cases.
- Community adult services were involved in the Commissioning for Quality and Innovation scheme (CQUINs) which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. CQUINS can be national, regional and local. The delivery of CQUINs is performance managed in partnership with the clinical commissioning groups (CCGs), NHS England and internally via the trust's CQUIN Monitoring Group and Quality Management Group. Compliance was subject to ongoing discussions with CCGs and penalties were applied quarterly.

Competent staff

- A corporate induction was completed by all staff who joined the service. Staff told us new staff also received an induction at locality level. New starters were allocated two weeks as supernumerary status so they could be oriented and get established into their roles, including shadowing more established members of staff. For example, new adult community nurses shadowed a band 7 and were supervised by the band 7 for practical work and completed their mandatory training package.
- Trust records showed 100% of staff had attended a corporate induction programme.
- Staff training and development was supported by management. We found services encouraged skills development. Staff of different grades confirmed that training needs were identified as part of appraisal, and staff could request further training that was relevant to their role.
- Community nurses we spoke with told us they had regular one to one clinical supervision, and attended daily handovers and monthly team meetings which they found useful and supportive.
- There was one Parkinson's Disease CNS post within the community. As there were no similar posts in nearby geographical regions they felt there was a limited peer support network, though said they were well supported by their line manager. The Multiple Sclerosis CNS was also a standalone post who had established links with other CNS peers and a nurse consultant within north

London, and received good support from the adult community rehabilitation team. Both CNSs considered their caseloads were as expected within the geographical area.

- The trust's CNSs provided education and training for student nurses and community nursing clusters in relation to their particular speciality, for example Multiple Sclerosis.
- Joint visits with GPs could be arranged for nursing staff for complex cases to enhance learning and development.
- The trust facilitated and encouraged teaching and learning between staff groups. For example, a consultant geriatrician provided simulation training to primary care multidisciplinary teams on starting the conversation on end of life care and advanced care planning. The training included sensitively raising the topic of dying with the patient, encouraging them to express wishes, dealing with family, writing and recording advance care plans.
- The Quality End of Life Care for All (QELCA) training programme had been rolled out for Hackney community nurses by St Joseph's Hospice. It was designed to be both visual and practice based. It involved classroom learning and witnessing care on St Joseph's hospice wards as well as a day with their community palliative care team. The training was five days in length and we were told that 10 adult community nurses had completed it.
- Community staff attended 'Foundations in Palliative Care' which was also run by the hospice. It followed a national education drive around care at end of life and multidisciplinary working which was offered to primary care providers.
- Staff appraisals were completed annually with a mid-year review where objectives for further development were set out. Managers acknowledged that appraisal completion had been challenging historically. One member of staff told us the recently introduced appraisal form was long and not user friendly.
- The trust's target rate for appraisal compliance was 85%. Between April 2014 and March 2015, the overall appraisal rates for staff in the community adult's service was 77%. In April 2015 the trust moved to an online appraisal reporting system; however the trust data was not sufficiently accurate to present a complete record of completed appraisals for the period April 2015 to March 2016. The trust was working to address this and ensure all staff had received an appraisal.

Multi-disciplinary working and coordinated care pathways

- We found numerous examples of multidisciplinary working which cut across many aspects of care and support. Multidisciplinary and partnership working was facilitated by teams and services being co-located across the trust's estate and in other centres, such as local authority buildings. This enabled staff to share information about patients, seek advice and guidance and facilitate referrals.
- Specialist clinical leads worked effectively in multidisciplinary teams. For example, the clinical lead for the specialist podiatry service maintained links with other specialists including physiotherapists and occupational therapists.
- The adult community teams were aligned to local GP surgeries for closer working and held monthly meetings with GPs. Nurses had good working relationships with local GPs and told us they accessible to discuss patients' needs and care. They held monthly meetings with GPs and social workers to discuss patients and prevent avoidable A&E attendances.
- Adult community nurses had access to specialist supported from diabetes and tissue viability nurses to effectively care for patients with complex needs. The podiatry teams had good links with the adult community nurses and GPs; however staff in the podiatry team told us communication with vascular and orthopaedic clinics was not as effective as it could be. We were told that the nurses could only contact these services via the GP. This was time consuming and delayed patient care.
- Within community end of life care services, we saw evidence of multidisciplinary working taking place which aimed to support patients at the end of their lives by providing care and treatment, emotional support and ensuring that patients' wishes were heard and respected. Multidisciplinary working was observed between Homerton University Hospital and the community, and across teams within the community setting providing end of life care.
- We observed a palliative care multidisciplinary meeting held at Homerton University Hospital which was

attended by staff working both at the hospital and within the community. The meeting aimed to assist the transition between inpatient care and the community and strengthen links between community and hospital staff. Staff present at the meeting included the palliative care consultant, palliative care lead nurse, palliative care CNSs, specialist social worker, palliative care occupational therapist and psychological therapist.

- During the multidisciplinary meeting both new referrals and existing patients were discussed. Care planning was agreed and electronic records for both the hospital and St Joseph's Hospice were updated. Spiritual, psychological and family needs were taken in to consideration during the planning.
- There was good communication between the adult community nursing, GPs and St Joseph's Hospice. The community nurses attended the Gold Standards Framework Meetings. We observed a meeting involved with coordinating the end of life care for patients at a GP surgery. An adult community nurse, GPs and a CNS from St Joseph's Hospice were in attendance. During the meeting we observed professionals discussing specific patient care including a blood test for a patient with low sodium, feedback from the adult community nurse regarding attending to a wet dressing and a multidisciplinary approach to monitoring pain relief. Referrals to the community nursing team were also discussed so that appropriate plans could be put in to place.

Referral, transfer, discharge and transition

- Community adult services had referral pathways and procedures in place. Referrals to community services were from a variety of sources including GPs, practice nurses, adult community nurses, patients being discharged from hospital, complex cases in nursing and residential care homes, and others including the police service. Staff at the adult community rehabilitation team (ACRT) told us there were clear criteria for referral of patients which meant that inappropriate referrals could be identified.
- The patient records were reviewed showed that discharge and transfer forms were completed appropriately and all relevant patient information had been passed on to other services, for example to the patient's GP.
- Referrals for the wheelchair service were reviewed by a clinician and prioritised based on the health risk to the person being referred. Urgent referrals were seen within five working days and standard referrals were seen within 20 working days. Once a referral had been screened the person being referred was contacted via telephone or post to arrange an appointment.
- The integrated independence team (IIT) was a service set up to avoid admissions where possible by triaging patients in the community to avoid them being admitted to hospital, or by working with patients who had been admitted to hospital after they were discharged.
- The IIT had an urgent two hour response time for patients on the caseload. Staff told us that if an urgent task was received, the team taking the referral would contact the patient to establish the nature and urgency of the call and to provide interim advice. Patients with non-urgent needs would be offered an appointment for a visit from a care coordinator on a specific day based on the treatment required.
- The IIT team told us they could not commission new care packages at weekends. Staff told us new providers were tendering to provide weekend care and this was work in progress.
- We viewed a range of care pathways at the community learning disability team, including the community nursing visiting clinic intramuscular injection pathway, the physiotherapy care pathway for people with learning disabilities and the clinical psychology care pathway for assessment of a learning disability. These outlined the patient's journey through the services, as well as the criteria for accessing the service, and any exclusion criteria. All the care pathways we viewed had flowcharts that mapped the patient's journey through the service.
- The palliative care occupational therapist worked alongside the occupational therapists within Homerton University Hospital and St Joseph's Hospice, planning for discharge by discussing home arrangements and equipment required. Formal handovers were organised for complex cases.
- Some of the trust's CNSs worked within the hospital and in the community. This enabled them to have continuity with patients after they were discharged from hospital and be involved in their plans for being discharged in to the community.
- Patients being discharged from hospital and in need of end of life care would be referred in advance by Homerton University Hospital to the adult community nursing team. A team leader or deputy team leader

would go to assess the patient the same day. Although a two-hour timeframe was normally provided for assessments, they would usually aim to see palliative patients more rapidly. Actions were put in to place quickly including ensuring that 'just in case drugs' and the appropriate number of daily visits were arranged.

- We found there were difficulties with transferring Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and treatment escalation plans between the hospital and community services. Staff told us this was due to different computer systems in place. Therefore a new DNACPR form was completed for each different setting where the patient was provided with care. We were informed by the palliative care consultant at Homerton University Hospital that there were plans for a pan-London DNACPR document which they were waiting to be introduced that would help resolve the problem, although this had not been communicated to all staff working within the community.

Access to information

- Staff working in community adults services had access to the trust intranet and the internet to enable them to find information, such as policies, guidance materials or research.
- The trust displayed posters and guidance to staff and patients at appropriate points across community service locations. For example, there were posters on identifying sepsis and the protocols for escalating deteriorating patients, and notices containing the contact details for safeguarding advice and support.
- The trust was taking steps to move all services to 'paper light' working, to reduce paper-based systems and records and transition towards networked computer based systems. We saw this in practice at the Kenworthy Road Health Centre. The full roll out of the new system across all sites and services was planned for the end of 2017.
- The electronic system used in the hospital was different to that used within the community. Some adult community nurses told us this could sometimes create confusion around discharge information because there was a set format for presenting discharge information to community services. On the whole this was adequate but on occasions it did not always contain all the required information.
- All staff within the community end of life services had access to 'Coordinate My Care' (CMC), a central electronic system used by GPs which held clinical care plans and records of patient wishes for those coming to the end of their life, including their preferred place of care/death. However, access to CMC varied so that some staff had read only access, some had modify rights and senior staff could create records so they were not reliant on GPs to update or input information. While staff were able to have discussions relating to advanced care planning with patients, some were reliant on GPs or senior staff to record these in CMC. We were informed that plans were in place to improve this through an upgrade in the electronic system which would enable all staff access to CMC.
- The palliative care occupational therapist had remote access to the records held by St Joseph's Hospice so that they were able to see what work had been undertaken with the client and any referral details.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of their responsibilities in relation to the Mental Capacity Act 2005 and could describe how they applied it in their daily work. We found overall that the service complied with the Mental Capacity Act 2005 Code of Practice (2007).
- We saw examples at the learning disability service of records of best interest meetings that had been held when patients lacked capacity to make a decision for themselves.
- Procedures were in place for patients at the learning disability service who lacked capacity to have access to an Independent Mental Capacity Advocate (IMCA) when serious decisions about their health and welfare needed to be made in their best interests. We did not see evidence of the referral rates or patterns of community adults services overall performance in regards to IMCA referrals.
- We saw that verbal consent was sought as a matter of routine for care to take place and nurses involved patients in decision making about their care. Consent was clearly written in notes and permission to share information was gained on day one. Separate written consent was sought for use of digital images. For example staff took photographs of pressure sores for monitoring purposes. We saw that staff discussions with patients around current treatments were in line with good practice for informed consent.

Good

Are services effective?

- Patients we spoke with told us staff always recorded their consent prior to providing care or treatment.
- Care plans were discussed with patients in case of future lack of capacity to ensure all wishes were recorded. During one visit we observed staff discussing issues including lasting power of attorney for health, welfare and finance, and advance decision making to refuse treatment in relation to the patient's percutaneous endoscopic gastrostomy (PEG) feeding tube. Relatives were included with the discussions at the patient's wishes.
- We observed a multidisciplinary meeting involved with coordinating the end of life care for patients at a GP surgery. An adult community nurse, GPs and a CNS from St Joseph's hospice were in attendance. Discussion took place around individual patients and consent, DNACPR and capacity.
- The trust incorporated Mental Capacity Act and Deprivation of Liberty Safeguards training into mandatory training on safeguarding adults level 2. At the time of our inspection training levels for this training was below the required target of 90%. Compliance with level 2 training was recorded at 72% at the time of our inspection, which could mean some staff did not have an appropriate understanding of their responsibilities in this area. A task group to reduce the backlog in training comprising of two psychologists and two consultant psychiatrists was put in place to deliver MCA and DOLS training. Training was delivered by psychologists, psychiatrists and the two members of the Safeguarding Adults Team predominately in acute services; however there was a plan to make this training accessible to community based staff.

Good

Are services caring?

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

Summary

We rated the community adults services as 'good' for caring because:

- Patients and their relatives consistently reported positive feedback about the care and treatment they received.
- We observed staff treating patients in a kind and compassionate manner.
- Staff were committed to ensuring patients' wishes were central to their care and treatment
- Patients and their relatives were encouraged to be partners in their care planning and were enabled to participate in care activities.
- Staff understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives.

However:

- There was a low response rate to the Friends and Family Test across community adults services.

Compassionate care

- We spoke with 20 patients and their families or carers as part of this inspection. They told us that staff were caring and treated them with dignity and they spoke positively about the staff and services they were using. During our inspection we attended patients' homes with adult community nurses. All of the feedback we received from patients was positive.
- The trust participated in the Friends and Family Test (FFT) to seek feedback from patients. The trust provided aggregate FFT data for all community services for the three months prior to our inspection. 94% of service users would recommend the trust, similar to the England average of 95%. However, there was a low overall response for community services at less than 5%.
- We observed staff showing empathy and compassion towards patients. We spoke to one patient who had attended their appointment on the wrong day, they were not automatically sent away, but an appointment was fitted in for them at a convenient time.
- As part of the inspection process, we sent comment cards for patients to provide us with feedback about the service and staff. 100% of the cards completed had positive feedback in regards to how patients were treated by staff.
- We observed a patient being treated at the tissue viability nurse (TVN) complex wound clinic at Fountayne Road Health Centre. The staff were compassionate with the patient and the patient was treated with dignity during their visit.
- We observed a Diabetes Eye Clinic during our inspection and witnessed staff there demonstrating a very kind, patient and professional service to patients. In each case, we observed the practitioner welcome the patient, explain what was going to happen, listen intently to what the patient said, and answer questions in a clear and accessible way. The approach was tailored to different patients, for example, speaking clearly and in plain English to patients with hearing impairments. Staff assisted patients with using equipment and gave encouragement and praise. Appropriate health and well being advice was also provided.
- We saw a number of thank you cards from patients and their relatives displayed at different community adults services. Feedback in these cards included: "thank you for all your hard work and constant support", which was representative of the messages in each of the cards we looked at.

Understanding and involvement of patients and those close to them

- Staff we spoke with were committed to ensuring patient wishes were central to their care and treatment, and they were skilled in sensitively managing conversations with relatives to ensure the patient's voice was heard.
- We saw staff interact with patients, ensuring they were fully involved with decisions made around their care and treatment. Relatives were also involved in decision making where this was agreeable to the patient. One patient we visited had difficulty talking, and we saw staff ensuring that they were happy for them to confirm information with a relative. The staff member regularly

checked back with the patient to reinforce that they were the final decision maker. On another visit we observed the nurse was careful not to take over and were told the patient was independent prior to surgery and was working towards this again.

- In our discussions with staff, patients and carers we found that there was an appropriate rehabilitation focus and that patients were encouraged to be partners in their care planning and enabled to participate in care activities.
- Patients told us they were very happy with the adult community nursing service. They told us nurses arrived on time, were polite and friendly and explained what they were doing.
- Patients accessing Adult Community Rehabilitation Team services could access therapy treatment and self-management folders. These folders were also available to patients of other services.. This gave patients information on understanding their medical record, therapy advice as well as support networks they could access in the community.
- The patient and family were involved in discussions about how regularly an adult community nurse would visit a patient needing care at the end of their life. We were told some families wanted to provide care themselves and their decisions were respected. Families were given advice regarding what type and how much care was required. Consideration was given to the ability and confidence of carers and relatives involved and weighed up with an assessment of risk. Specific advice was given about essential care such as when they needed to attend to a wound dressing.
- The community learning disability team's internet page carried information on advocacy services and local support groups.

Emotional support

- Staff demonstrated that they understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives.
- Staff told us they offered support to patients, in particular band 5 adult community nurses provided extra support visits for patients who had additional care needs, sometimes visiting the patient's home more than four times a day.
- Emotional support was provided by specialist palliative care nurses, who provided bereavement counselling and offered support for patients and families.
- We observed staff talking sensitively to patients, gently prompting them to plan ahead so that future needs could be catered for.
- Community staff who provided end of life care were aware of the psychological services offered at St Joseph's Hospice which they could make referrals to when support was required by the patient and/or their relatives or carer. We observed a counselling referral being discussed, with a plan for a referral to be made for one patient.
- Staff told us there was good access to patient/carer support groups for individuals with muscular sclerosis, as well as local psychology services within the mental health team.
- The trust allocated staff time for staff to have contact with families following a patient's death when desired by the family so they could continue to provide emotional support and connection.
- Adult community nurses told us there was a trust policy providing guidance on how to deal with bereavement. When the death was unexpected the police were notified. If the death occurred out of normal working hours, the GP would be contacted. If a syringe driver was in use, it was turned off until the GP arrived. The local hospice would be informed and the family would be spoken to the following day regarding collection of equipment from the home and if required by the family, a referral would be made to the hospice for bereavement counselling.

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 the community adults services as 'good' for responsive because:

- Community adults services had a model of integrated community teams across nursing, therapies and social care to ensure patients received joined up working.
- The trust had invested in a dedicated advocacy and support services to engage local communities and 'hard to reach' populations
- Staff were responsive to the needs of vulnerable patients, such as those living with dementia and learning disabilities.
- Community adults services managed complaints appropriately and there was evidence of learning from complaints.

However:

- Some of the trust's partners identified a need for greater out of hours community nursing input, which was not provided by the trust.

Planning and delivering services which meet people's needs

- Community adults services had a model of integrated community teams across nursing, therapies and social care to ensure patients received joined up working. The aim of this service model was to improve patient outcomes and experience through bringing existing community services from health and social care into a more combined way of working. The model aimed to reduce the number of different professionals that patients needed to interact with, and reduce duplication of work, with an increased focus on personalised care and self-care.
- Staff told us they worked with local service commissioners, including local authorities, GPs, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- A variety of treatments could be carried out in the adult community nursing treatment rooms, including leg ulcers and wound care, preventing the patients having to visit their GP or hospital.
- There was a large amount of printed information available to patients across the community adult services we visited. Patients could also access information on the trust's website. We saw there were extensive displays and leaflets covering condition-specific topics, general health advice and signposting to local health and social care services.
- We saw that complex care plans were in place which identified patient's care choices. One care plan that we saw indicated the patient's clear preference to die in their own home rather than move in to a care home.

Equality and diversity

- There was a trust equality and diversity policy in place. It detailed the statutory and mandatory training required and the standards and behaviours expected of all staff.
- Staff we spoke with told us they had received equality and diversity training as part of the trust's corporate induction. At the time of our inspection the compliance rate for completion of this training was at 98% across all community adults services.
- The service had access to a language interpreter service and staff we spoke with knew how the system worked. Staff told us the service worked effectively for most interactions with patients, but in some specific circumstances it was not effective. For example, some community practitioners expressed difficulty in using the telephone translator service when teaching non English speaking patients how to administer insulin and measure blood glucose levels.
- We attended a MDT clinic meeting for the locomotor service. We were told that Turkish patients had been identified as a 'hard to reach group'. In response, the trust had invested in a dedicated advocacy service to meet the needs of the local Turkish and Kurdish population. A specific Turkish speaking link worker had been employed. Patient satisfaction surveys were made available in Turkish. Patients requiring the use of the

advocacy service were seen at St Leonard's hospital where clinics were structured around these services. The Grünenthal award had been awarded to the trust's Turkish pathway, for the translation of material and the implementation of Turkish focus groups.

- The palliative care consultant at Homerton University Hospital had worked with religious leaders and community groups in response to concerns raised by the orthodox Jewish community around the trust's end of life care protocols. This meant information could be shared and a better understanding of the community needs could be gained and responded to.
- Patients with a sensory impairment had access to the trust's sensory services team. Staff told us they could book appointments to make joint visits with the sensory impairment team.
- All the trust information leaflets we saw were in English. Staff told us all of the trust's printed information was available upon request in any language from the trust's accessible communications team.
- We observed a multidisciplinary meeting involved with coordinating the end of life care for patients at a GP surgery. An adult community nurse, GPs and a CNS from St Joseph's Hospice were in attendance and shared information regarding people's individual needs. Advance care directives were discussed in relation to one person's religious faith and their treatment choice. Another patient's need for an interpreter was also raised and noted.
- We observed that the trust had worked hard to reach all areas of the community. Senior staff at St Joseph's Hospice recognised this saying that 'engaging with such a diverse community was a challenge and adult community nurses worked hard to have the dialogue with the community'.

Meeting the needs of people in vulnerable circumstances

- The trust safeguarding team provided support for patients living with dementia and learning disabilities and provided advice and guidance to community practitioners in supporting patients with specific needs.
- The staff we observed were responsive to the needs of patients living with dementia. One member of staff explained that they would provide information to patients in a way that best suited their needs and would try to visit with a member of staff known to the patient to reduce anxiety and confusion. Care planning for patients with dementia was discussed at multidisciplinary meetings.
- Patients with learning disabilities were seen at clinics with their carers. For convenience and for a less stressful experience they were given appointments first thing in the morning or the last of the day. Such patients were not seen on their own. Staff worked with carers to ensure advocacy, familiarity and knowledge of patients.
- The community learning disabilities team provided a range of services for people with a learning disability. We saw a range of leaflets had been produced in easy read format by the learning disabilities team and were readily available across the trust's locations.
- Central equipment stores had appropriate equipment for bariatric patients and staff could access this equipment when needed.

Access to the right care at the right time

- Referrals to the adult community nurses were triaged at the point of contact with the service and the caseload allocated accordingly. Adult community nursing teams did not operate a waiting list and the service prioritised patients for visits on a daily basis.
- Arrangements were in place for the trust to monitor when patients did not attend (DNA) appointments.
- Managers for adult services told us there were currently 16,000 referrals for locomotor services. The locomotor service consistently met their waiting times, however, staff felt a sense of pressure but felt it was supported by excellent leadership. Staff in the ACRT had not been able to meet their five week wait target due to urgent cases taking priority over the five week non-urgent wait.
- At the time of our inspection the trust was implementing demand management processes and revising care pathways to manage the flow and demand. This was to be reviewed in order to see if more resources were required or if the specification needed to be altered.
- Services such as the tissue viability nurse (TVN), speech and language therapy (SALT), physiotherapy and occupational therapy were available Monday to Friday with limited weekend availability.

Good

Are services responsive to people's needs?

- Managers within the community nursing teams told us that patients requiring end of life care were prioritised, sometimes leading to a case being re-allocated so that care was received in a timely way.
- The trust's adult community nurses provided a daytime service only, and there was no trust community nursing provision between 11:30pm and 8:30am. Managers in the trust told us they had piloted an out of hours community nurse service through a local out of hours GP service, but had found that the service was used very little, particularly for end of life care, and had not provided value for money and had therefore been discontinued.
- Some of the trust's staff and external partners felt that out of hours community provision was an area that needed more input by the trust. Patients requiring out of hours medication or support had to contact a GP via the City and Hackney Urgent Healthcare Social Enterprise (CHUHSE) service or call for an ambulance. For end of life care, an out of hours specialist palliative care service was provided overnight by a registered nurse funded by the Marie Curie charity. However, not all end of life care patients were referred to this support. Some staff felt that a more specialist service to assist with pain and breathing was required but was not available currently.
- The palliative care occupational therapist was usually able to visit patients on the same day if required. If workload did not allow this, or a patient needed to be seen at the weekend, then they could refer the patient to the integrated independence team who would visit and put in place any emergency equipment and then refer back to the therapist.
- We found the Parkinson's Disease CNS was responsive to patients' needs. Where necessary they varied their hours, sometimes working in the evening so that they could visit the patient when the carer was also there. This minimised disruption to the patient and enabled professionals to liaise closely about patient care and treatment. However, being a lone worker the CNS was unsure how long they would be able to sustain this flexibility, and there was no cover for them when they were on leave.

Learning from complaints and concerns

- From January to December 2016, the trust received 23 complaints relating to community adult services and one for end of life care services. Of these, five were upheld, 10 were partially upheld and eight were not upheld. One complaint remained open from July 2016. No complaints were referred to the ombudsman for independent adjudication. On average, the trust took 23 days to respond to complaints regarding community adults and end of life care provision.
- Patients of the trust's community adults services could submit feedback and complaints to the trust Patient Advice and Liaison Service (PALS). Information on how to access PALS was displayed in prominent areas in all of the clinics and health centres we visited.
- The community learning disability service had an easy read complaints policy for people who used services.
- Staff told us they always tried to address complaints or concerns immediately to see if they could be resolved for people there and then. If they could not be resolved in this way, staff told us patients would be given the contact details of PALS. We were shown the information pack people received from the ACRT team, this included a PALS information leaflet. Staff added that they did not get many formal complaints. Senior managers of the community adults services highlighted that most complaints were informal, but there were some that went through PALS which were dealt with formally.
- There was evidence of learning from complaints. Staff told us that outcomes of complaints were fed back through local meetings and they were able to describe examples of learning from previous complaints. Senior managers told us that one theme they had found in complaints had been around nurses visiting later than the time specified. There was recognition of the impact of delayed appointments on patients, but also recognition that sometimes delays were out of their control. Following these complaints management had introduced a two hour time frame instead of specifying a morning or evening slot to patients. Nurses were encouraged to call patients if they were going to be late. We saw this in practice when a nurse called a patient to say they were running late and gave an estimated time of arrival.
- Senior managers told us that some complaints related to staff behaviour and attitude. We were told some services had used temporary staff to cover rota gaps.

Good

Are services responsive to people's needs?

There was recognition that some temporary staff may not have demonstrated the trust's values or expected behaviours. Examples included unprofessional appearance and not apologising for being late.

- Following these complaints, management commissioned bespoke training around professional behaviours, conduct and self-awareness for band 5 nurses. This took place over five days during 2016. Nursing staff told us they would now challenge each other, for example if someone's uniform did not meet trust standards.
- On home visits a leaflet was left with patients that explained the Friends and Family Test, the role of PALS as well as complaints. Contact details for adult community nurses and information about the service was also provided.

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 the community adults services as 'good' for well-led because:

- Staff were aware of the trust's values and understood how they related to their day to day work.
- There were appropriate plans in place to develop the community adults service.
- There were effective governance and reporting structures in place to enable the escalation of performance and risk information.
- Senior leaders had a clear understanding of their services, local risks and challenges, and realistic plans to develop their services.
- Staff told us managers were accessible and supportive and reported a positive culture in community adults services.
- The trust facilitated patient involvement user groups to seek feedback and support service development.
- There were some areas of innovation including the introduction of extended scope practitioners.

However:

- There were some isolated reported concerns where staff did not feel that their managers listened to their ideas or responded to their concerns.

Leadership of this service

- There were some very established leaders within the community adult services, including senior staff who had worked at the trust for many years. The trust had also appointed new senior staff in some services. Some of the community therapists we spoke with felt that the appointment of a new senior leader had brought in fresh ideas and invigorated the therapies services. All of the senior leaders we spoke with, including the trust leadership team, had a clear and detailed understanding of community services provision, including the local risks and challenges, and had realistic plans to develop the services.
- The trust adopted a system whereby executive directors 'sponsored' different services to ensure there was senior representation of all services at the trust board. Executive directors were allocated a community service and acted as a conduit between the senior leadership team and that service. This included site visits, focus groups with staff and 'walk arounds'. This gave staff the opportunity to speak with directors about what it was like to work in the organisation and raise any concerns.
- Most of the staff we spoke with said that managers were accessible and had an open door policy so they could report concerns. Middle managers said that they were able to contact their line managers when necessary. Local team leadership was seen by staff as effective and most staff said their line managers were supportive. However, there were some isolated reported concerns where staff did not feel that their managers listened to their ideas or responded to their concerns in a meaningful way. We shared specific information about this with trust senior leaders for further investigation.
- There was a lead community nurse who provided specialist input, supported managers and helped resolve challenging situations. There were also two community matrons who worked with the staff in each cluster. Nurses referred to the matrons for support in complex cases, for example where there were safety concerns or a referral to social service was required.
- Staff in the integrated independence team told us the leadership team was accessible and approachable. Nurses at the complex wound clinic described their manager as dynamic and supportive and they were proud of the improvements made in the service.
- The trust's chief nurse was the executive lead for the end of life care service within the community. The service was integrated within both adult and children's community health, and the chief nurse was supported in the role by the leads from both of these services.
- End of life care services in the area of City and Hackney were delivered by a range of providers including Homerton University Hospital NHS Foundation Trust. These were represented on, and shared information via the City of Hackney End of Life Care Board chaired by the clinical commissioning group's clinical lead. Homerton University Hospital also had an End of Life

Care Board, with multi-agency representation. The board was chaired by the palliative care consultant at the hospital and attended by the lead nurse, head of care at St Joseph's Hospice, end of life lead from the commissioning group, medical director and community nursing lead.

- Managers within the trust acknowledged that there were challenges with regards to who had overall responsibility for a person's care at the end of life stage. However, there was collaborative working towards a solution, and an aim to move towards a model where the team with the most input would have ownership. The trust was working on the details with other agencies involved in end of life care to put the model in to practice. The introduction of an electronic system that could be shared between GP practices and other community health care providers which was planned for later in the year was seen as being instrumental in this.

Service vision and strategy

- The trust's vision and values were displayed on posters in of the community areas we visited. The staff we spoke with were aware of the values and understood how they related to their day to day work.
- There were appropriate plans in place to develop the community adults service in light of changes to local commissioning arrangements, changing local needs, and the available resources to deliver the range of services provided by the trust.
- Senior management stated their plan for the next four years was to work more efficiently and closely with GPs, doing pilots on embedding community nurses in GPs and cross covering. There was a desire to implement the 'Buurtzorg model' with the integration of health and social care professions in managing care.
- There were plans to develop joint working between community nurses and GP practices. Adult community nurses were to be placed in two GP surgeries to encourage information exchange and better rapport. This was a work in progress and managers were reviewing potential models to see what would be effective.
- Managers were aware of the difficulties of uniformity and coordination as they were working alongside 43 GP practices, and considered that the strategy would help with bringing better consistency. We were told agencies worked well together without competition but they acknowledged that more collaborative working was required with primary care services.
- Senior managers within community nursing told us they had spent the previous four years rebuilding the service. This was done by re-profiling the leadership structure and improving relationships with GPs.
- There was an expression to replace the community matron role with advanced nurse practitioners to care for acute care patients in the community. At the time of our inspection a business plan was being proposed for the end of 2017.
- Managers indicated that they now had a better idea where gaps were within the end of life care service, for example there had been some difficulties with ensuring that anticipatory drugs were always in place, and they wanted to make improvements to this.
- Senior managers told us there had been more emphasis on developing the end of life service over recent months to provide a clear structure and guidelines for staff within the service. There was a focus to develop a 'joint strategy pathway'. This would entail setting out guidance for all staff within the trust community services involved with end of life care so that there was consistency and confidence in the care and treatment provided.
- We were shown a document which had been discussed at the Community End of Life Board which provided staff with guidelines around identification of a patient as being in the last years of life and in the last days/weeks of life, actions to be taken following patient deterioration and sources of advice in hours and out of hours. The document was in draft and being consulted on with staff.
- The aim was for an integrated approach, rather than the hospital inpatient and community being viewed separately. The aim was to further embed a seamless pathway from hospital to the community, which would involve patients being seen by the community nursing team within 48 hours of admission to make plans to get patients home. More community nursing staff attending the hospital multidisciplinary meeting was also an objective.

Good

Are services well-led?

Governance, risk management and quality measurement

- There were effective governance and reporting structures in place to enable the escalation of performance and risk information to senior decision makers within community adults services and the trust senior leadership team. Governance arrangements facilitated the sharing of information from management to front-line staff.
- The Head of Nursing reported to the Divisional Operations Director, who reported to the Chief Operating Officer who was an Executive Director on the trust Board.
- Clinical managers of community services attended weekly complaints, litigation, incidents and PALS (CLIP) meeting with the Head of Nursing, during which information and learning from incidents, complaints and feedback was discussed. Managers were required to share this learning with their respective teams in local team meetings. Each team across the trust had weekly and monthly meetings to review incidents, performance issues and planning, amongst other topics.
- Clinical operational managers attended monthly meetings where finance, performance and activity measures were discussed. They also reviewed key governance indicators. The clinical operational manager for each area produced monthly performance reports which fed into the trust-wide governance system.
- The trust used a system of divisional risk registers to formally record and update risks and issues. We reviewed a sample of risk registers and found there was appropriate recording of concerns, actions taken, planned actions, and risk ownership. There were systems for formally removing risks from the register which ensured that matters were managed appropriately to their conclusion.
- Risks identified by management included access to appropriately experienced and competent staff, external changes to commissioning arrangements such as retendering and bidding for services. There were action plans to mitigate risks. For examples plans to improve recruitment and retention of adult community nurses. Management acknowledged there would be changes as the community nursing role transitioned. Management were testing new models to balance and develop opportunities for staff and look at new ways of working and integrating teams.

Culture within this service

- Staff generally reported a positive culture in community adults services. Practitioners spoke positively about working for the trust, their teams and their work. Staff reported that morale was high across community adult services teams. However, some staff stated the caseload was sometimes difficult to manage and that they sometimes worked longer than their shifts, which impacted on their morale.
- Therapy staff said they were proud to work for their teams and enjoyed their work. All the therapy staff we spoke with were positive about integrated services and felt positive about their role and contribution to this.
- We saw that managers made arrangements for staff to receive psychological support at times when this was necessary. Staff told us they felt well supported emotionally and psychologically within their roles.
- Senior managers told us they felt it was important for community staff to showcase the work they were doing out in the community as they felt it could "go under the radar".
- Some managers told us there was limited appetite for change amongst some more established members of staff in the community adults service. Senior management told us "we need to strengthen the leadership in the teams to make it a good place to work, and we have to make opportunities for those staff who want to develop and change the way of working". Emphasis was given to training and education in order to give staff the competency to work in a changing world.

Public engagement

- Some community services facilitated patient involvement user groups to help co-design services, seek feedback and provide opportunities for patients to share their experiences of managing their conditions.
- The locomotor pain service facilitated patient groups which provided support and advice to the next cohort of service users about their experiences and how to get the most out of the service.
- The trust's VOICES survey sought the views of bereaved relatives and carers about the care experienced by their loved ones in the last three months of life. A local survey was commissioned within the area of City and Hackney in 2015 to gain knowledge about the quality of service and identify areas for improvement. The quality of

healthcare received, and ratings for dignity and respect were above the national average. Overall quality of adult nursing care was found to be lower than the national average. Pain management was more successful in in-patient settings than in the community, which was in line with national results.

Staff engagement

- Most Band 5 and Band 6 staff we spoke with told us they felt comfortable in their role and well supported in their development.
- Managers within adult therapies spoke of plans to hold an away day and invite service users to help review services, celebrate the service's achievements, and troubleshoot some of the challenges.
- The trust sent regular newsletters and updates to staff to ensure they were kept up to date with developments, news and achievements. This included regular all staff emails from the trust chief executive.

Innovation, improvement and sustainability

- The trust had extended scope practitioners in physiotherapy. These staff displayed skills beyond the expected level of competency. For example, they carried our interventional injections under PGDs and undertook ultrasound in their clinics. This enabled one stop diagnostic interventions within the community, reducing the need for referrals.
- We saw physiotherapy prescribers who could administer Botox for spasticity management, incorporating diagnosis and intervention.
- To establish quality priorities within the community and to measure outcomes, management spoke with patients and patient's representatives, and surveyed staff in order to identify key priorities needing action.
- The trust's MSK pain service had been shortlisted for a Health Services Journal award. Patients had provided very positive feedback about this service.
- Management detailed improvements to the end of life care provision, whereby a more strategic approach was developed to encompass early recognition and record keeping. This was done across the community and with GPs. There was allocated as a key organisational priority.
- The trust's Practice Development Nurses provided accessible learning and development support for staff working in the community.