The Royal Marsden NHS Foundation Trust

RPY

Community health services for adults

Quality Report

The Royal Marsden Community Services
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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)
RPYX1	The Royal Marsden Community Services	Green Wrythe Lane Health Centre	SM5 1JF
RPYX1	The Royal Marsden Community Services	Robin Hood Lane Health Centre	SM1 2RJ
RPYX1	The Royal Marsden Community Services	Jubilee Health Centre	SM6 0HY
RPYX1	The Royal Marsden Community Services	St Helier Hospital	SM5 1AA

This report describes our judgement of the quality of care provided within this core service by The Royal Marsden 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 The Royal Marsden NHS Foundation Trust and these are brought together to inform our overall judgement of The Royal Marsden NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated the service as requiring improvement overall because:

- There was a shortage of experienced nursing and therapy staff in the integrated community teams and insufficient time to complete holistic assessments.
- Learning from incident reporting was shared within the relevant teams however systems to share learning across teams were not embedded.
- Patient records were not completed in a consistent or thorough way. 50% of those we viewed did not have the appropriate risk assessments in place. This meant that before visiting nursing staff did not always have a clear understanding of a patient's health status when giving treatment
- Safety information provided by the trust identified they had a high prevalence of patients with pressure ulcers. We found staff were not consistently following best practice in their approach to wound assessments. This meant that changes to wound presentation were less likely to be accurately recorded and deterioration may not have been addressed as readily.
- Baseline recordings of patient observations were not always completed.
- Deprivation of Liberty Safeguards were not always understood and mental capacity was not always appropriately assessed and recorded for patients who may lack capacity. Staff were knowledgeable about the need to act in patient's best interest but were not clear about who could consent on the patient's behalf and how this information should be recorded in patients' records.
- Staff did not consistently use outcome measures to monitor patient progress. For example: key outcome measures such as the assessment of pressure ulcer risk and nutrition scoring.
- Staff were not following the quality standard for nutrition support in adults which required care services to take responsibility for the identification of people at risk of malnutrition and provide nutrition support for everyone who needed it.
- Few of the records we looked at documented people had been involved or encouraged to be partners in their care when assessing their emotional needs. However we found that in discussions with staff they gave examples and referred to practice that demonstrated they had considered the patients emotional needs although this was not always well documented.
- The arrangements for governance and quality performance did not always operate effectively. Not all risks and issues were known and those that were known were not always recorded.
- The approach to service delivery and improvement was sometimes reactive and improvements were not always identified or action taken.This meant the impact on the quality of care for patients was not always effectively monitored.
- Operational organisational processes impacted on continuity of care. We were not assured systems and processes were in place to effectively identify risks to patient care.

However we also found:

- There was a clear incident reporting system in place and staff were encouraged to report incidents.There was evidence of learning from incidents and evidence of improvements being made as a result of reporting and sharing the outcomes of incidents.
- Community staff were knowledgeable about safeguarding procedures and knew who they would report any concerns to.
- Community nursing staff had access to specialised equipment to meet patients' needs when required.
- Staff with specialist skills and knowledge were used by community teams to provide advice or direct support in planning or implementing care. Teams worked together in a coordinated way and mad appropriate referrals on to specialised services to ensure that patients' needs were met.
- Services were delivered in line with evidence based practice. Staff used clinical guidelines and protocols to inform their decisions about care and treatment

Summary of findings

- The service participated in national audits and developed action plans to make improvements
- Patients were given a choice of options to manage their pain.
- Patients received a caring service from staff that were kind and respectful toward them.
- Nursing and therapy staff treated patients with dignity, involved patients and their families in their direct care and supported them during times of crisis.
- The services provided a range of specialist therapeutic interventions.
- The trust was aware of the diverse needs of the people who used the service and they provided a range of support as required.
- The trust worked closely with commissioners, local authorities, people who use services, primary care services and other local providers to ensure it understood the needs of the population it served in order to plan and deliver services.
- Staff considered the needs of people who may have difficulty accessing services and adapted their care approach to show respect for cultural factors. There was evidence of learning from the complaints received from patients and families.
- Patients reported that they were satisfied with how to make a complaint and how they were dealt with.
- Leaders encouraged and supported staff so they felt respected valued and supported.

Summary of findings

Background to the service

The Royal Marsden Community Services formed Sutton and Merton Community Services (SMCS) in 2011. Various community health services were provided in the London Boroughs of Sutton and Merton. From 1 April 2016 The Royal Marsden Community Services stopped providing services to Merton and formed Sutton Community Services (SCS). Our report includes data from the 12 month period leading up to our inspection which was before the disaggregation of service and contains some data relating to Merton. We have included separate data where it was available. Our site visits during the inspection were limited to Sutton only.

The Royal Marsden NHS Foundation Trust provided adult community services to support people in staying healthy, to help them manage their long term conditions, acute care delivered in people's homes to avoid hospital admission and following discharge from hospital to support them at home. Services were provided in health centres, clinics, outpatient departments and in people's homes. Patients were offered a timely assessment and rapid social and health care input for patients who were in a "crisis" and would otherwise need a hospital admission.

Sutton and Merton community services (SMCS) was formed in 2011. Services variously cover the London Borough of Sutton (with some extended their catchment to Merton until 31st March 2016 when the service level agreement ended). Since 1st April 2016 Sutton community services provided a service to several parts of Surrey including Carshalton, Wallington, and Cheam.

Community nursing teams had been redesigned and Integrated Community Teams (ICT) consisted of community nurses, physiotherapy, occupational therapists and specialist nurses who aimed to support patients in the community as well as those being discharged from hospital back to their own homes. Specialist nurses included: tissue viability nurse, clinical nurse specialist quality and safety, respiratory nurse, heart failure nurse, physiotherapist, community dietician, diabetes nurse, practice educator however recruitment was still ongoing to fill some of the posts.

The population of Sutton was recorded as 191,000 in the 2011 census. There are a greater proportion of over 85 year old people in Sutton ((2.1% compared to London (1.5%). Sutton has an "older, larger than expected" population of people with learning disabilities. Minority ethnic populations account for 21% of the population in Sutton (2011 census)

Community services received a total of 510,693 attendances in the 18-month period from July 2014 to December 2015, with Community Nursing accounting for the largest share of these attendances (37%).

Our inspection team

Chair: Robert Aitken

Head of Hospital Inspection: Nick Mulholland, CQC

Team Leaders

Stella Franklin, Inspection Manager, CQC

Margaret McGlynn, Inspection Manager, CQC

Michelle McCarthy, Inspection Manager, CQC

The team that inspected services for adult community health services consisted of CQC inspectors and a variety of specialists including a nurses with a back ground in community service care provision.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

Summary of findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 19 and 22 April 2016. During the visit we spoke with a range of staff who worked within the service, such as nurses, specialist nurses, therapists and managers. We talked with people who use services, with carers and/or family members and reviewed care or treatment records of people who used services. We carried out an unannounced visit on 27 April 2016.

During the inspection we visited a number of teams based at four locations: Robin Hood Health Centre, Green Wrythe Lane Health Centre, Jubilee Health Centre and St Helier Hospital.

We spoke with a total of 45 community nurses and allied health care professionals, managers and administration staff and spoke with 13 patients and their relatives.

We reviewed the following services: integrated community teams which included community nurses, specialist nurses, occupational therapists, and physiotherapists. , rapid response and community intensive support services.

During the inspection we looked at patient care documentation and associated records and observed care in clinics. We reviewed meeting minutes, operational policies and staff records.

We reviewed comment cards and patient friends and family test information received from patients who used trust community services.

What people who use the provider say

We spoke with 13 patients and received positive feedback from most patients we spoke with. For example, two patients were unhappy that they did not know when community nursing staff would arrive, two told us they had a "good response in an emergency", staff were "friendly and they had felt listened too.

Patients were able to feedback in a number of different ways. For example; by phone, web link, paper, IPad or kiosk depending on the suitability for the service. Further developments to be undertaken in 2016 included: reviewing patient survey requirements for all services and extending the use of electronic collection devices across more services.

Patients and families who we spoke with during our onsite inspection told us that staff were caring and were always approachable.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that care and treatment is only provided with the consent of the relevant person.
- When patients (aged 16 and over) are unable to give consent because they lack the capacity to do so, the trust must ensure staff must act in accordance with the Mental Capacity Act 2005.
- The trust must ensure there are effective systems in place to identify, assess and monitor risks relating to the health, safety and welfare of people who use services and staff. This includes reporting systems and risk-management processes.

Summary of findings

- The trust should ensure that records contain accurate information in respect of each patient and include appropriate information in relation to the treatment and care provided, particularly with regard to risk assessments.
- The provider should take action to understand the shortfalls in recording of risk assessments and individualised care plans in the integrated community teams.
- The trust should review the staff compliment for community adult services to ensure there are sufficient numbers of appropriately skilled staff to meet patient's needs.
- The provider should strengthen the reporting on the assurance of effectiveness of governance arrangements to the trust board.
- The trust should review the paper and electronic records to ensure that the recordings are complete, accurate and do not contain variances and discrepancies.
- The trust should review district nurses' caseload management. The system presented a risk to patient care as patients did not have a dedicated named nurse responsible for monitoring and reviewing their care. Patients could see a different district nurse at every visit, which meant that continuity of care was a potential risk.
- The trust should review supervision processes. There was a lack of formal supervisory, clinical supervision or peer support arrangements in place for some staff. This meant that staff did not always have the support structure in place to enable them to discuss and review their role and the treatment they provided.

The Royal Marsden NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- There was a shortage of experienced nursing and therapy staff in the integrated community teams and insufficient time to complete holistic assessments.
- Patient records were not completed in a consistent or thorough way. 50% of those we viewed did not have the appropriate risk assessments in place. This meant that before visiting nursing staff did not always have a clear understanding of a patient's health status when giving treatment
- Safety information provided by the trust identified they had a high prevalence of patients with pressure ulcers. The trust were actively encouraging staff to report all pressure ulcers and had set targets to reduce preventable pressure ulcers. We found staff were not consistently following best practice in their approach to wound assessments. This meant that changes to wound presentation were less likely to be accurately recorded and deterioration may not have been addressed as readily.
- Baseline recordings of patient observations were not always completed.

However, we also found:

- There was a clear incident reporting system in place and staff were encouraged to report incidents. Learning was shared within the relevant teams however systems to share learning across teams were not embedded. There was evidence of learning from incidents and evidence of improvements being made as a result of reporting and sharing the outcomes of incidents.
- Community staff were knowledgeable about safeguarding procedures and knew who they would report any concerns to.
- Community nursing staff had access to specialised equipment to meet patients' needs when required.

Safety performance

- There were no Never Events reported between February 2015 and January 2016. Never events are incidents determined by the Department of Health as serious,

largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Data was collected electronically and a report produced for each area.

- The service monitored safety information through regular quality dashboard reports on safety indicators such as pressure ulcers, falls and medication errors.
- Between January and December 2015 there were 108 medication incidents recorded.
- The Royal Marsden Hospital participated in the NHS Safety Thermometer scheme used to collect local data on specific measures relating to patient harm and 'harm free" care. Data was collected on a single day each month to indicate performance in key area. NHS safety thermometer information for months of November 2015 and December 2015 showed a reduction in the level of patient harm due to pressure ulcers and falls, in two of the three Sutton Community service localities. An average of 90% of patients received harm free care between April 2015 and April 2016.
- The community nursing teams used the NHS safety thermometer. This is a tool used at the point of care to measure harm and the proportion of patients that had not suffered any harmful incidents during their treatment. The safety thermometer looked at the incidence of pressure ulcers falls and urinary tract infections. Analysis of the results was displayed for teams to see and discussed at team meetings.

Incident reporting, learning and improvement

- The trust had systems in place to report and record safety incidents, near misses and allegations of abuse. Between February 2015 and January 2016, the trust reported 795 incidents to the National Reporting and Learning System (NRLS) that occurred in a community health services (CHS), a monthly average of 66 incidents.
- The majority of incidents were classified as low harm; incidents peaked in November 2015 when 94 incidents were reported.
- 16 serious incidents were reported to the Strategic executive information system (STEIS) during this same period, all relating to pressure ulcers of varying severity. Seven were recorded as occurring in the patient's own home and two in residential care or nursing homes. Seven of the incidents occurred in Merton however as of the 31st March 2016 the trust no longer provided community health services for Merton patients.
- There was a policy for reporting incidents and staff told us they knew how to report incidents and were aware of the online reporting tools, policies, procedures and audits.Incidents reported to managers were reviewed at quality and safety meetings and key themes, trends and case studies highlighted. Some staff told us incident reporting worked well and outcomes were fed back at staff meetings. Other staff felt incidents were not always reported because of the time constraints and they did not always get to find out what had happened. Incidents sometimes took a long time to be investigated and feedback could be slow or non-existent.
- Learning from incidents was not always shared across teams, Staff told us they would get to know about incidents they were directly involved with however sharing between localities was dependent on individual managers feedback to teams. One nurse said they sometimes had feedback via an e-mail from one of the senior managers. Staff in another team said they discussed at team meetings sometime but they did not have them regularly.
- In one example of a medication error, staff identified changes had taken place and practice changed as a result of incident reporting and learning shared across all teams. Analysis of the incident had identified additional training and a change in procedures for community nursing staff. A performance improvement plan had been implemented with the training rolled out across all the relevant teams. Staff shared additional examples and root cause analysis (RCA) minutes evidenced action taken to learn from incidents.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that rates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Requires improvement

Are services safe?

- The trust's Duty of Candour Audit report (March 2016) stated that community services had the "largest numbers of incidents resulting in moderate harm and above due to category 3 and 4 pressure ulcers being graded as moderate harm as per NHS England Serious Incident Framework".
- Between 1 July and 31 December 2015, 46 incidents that resulted in moderate harm or above were reviewed.Results were compared with those from the previous audit from January to June 2015. Improvement included an increase 75% to 89%, in recording the number of patients being informed of an incident. There had been an increase in the number of patients offered a written apology from 38% to 53% between July and December 2015 which was a positive increase of 15% on the previous 6 months. 88% of patients had been asked if they would like a copy of the investigation report compared to 55% January to June 2015.
- An action plan was in place to re-audit compliance in December 2016 with a recommendation that the trust needed to "continue to raise awareness within the organisation of the "Being Open" and the Duty of Candour requirements. This was confirmed by staff we spoke with as not all staff were aware of the duty of candour and the need to be open and honest with patients when mistakes were made.There was some confusion as to what it meant, comments included,it's the "right to good care", All the managers we spoke with were clear about their duty of candour responsibilities and gave us clear examples of how they would use it in their work.

Safeguarding

- The February 2016 Minutes of the Safeguarding Children and Adults Committee Meeting (SCACM) reported that community adult's compliance level 1 training was 90%. Compliance with level 2 training had been reported as 68% with attendance data still to be confirmed that would bring it up to 80%. This was below the trusts target of 90%. The trust provided us with further information which confirmed 89% of staff had completed level 2 training in April 2016.
- Community nursing and therapy staff were knowledgeable about safeguarding procedures and knew who they would report any concerns to.
- We saw information about how to report any safeguarding concerns and safeguarding adults information was displayed in the hospital, clinic and community bases we visited.
- The trust's adult safeguarding lead reported to the clinical nurse director, clinical services and chief nurse. They provided quarterly reports to the Adult Safeguarding Monitoring Committee, Integrated Governance and Risk Management Committee (IGRM) and Quality and Risk Committee (QAR) as well as the Local Authority Safeguarding Adult Boards.This meant there was a clear audit trail and line of accountability for safeguarding within the trust.

Medicines

- Sutton clinical commissioning groups (CCGs) have authorised Non-Medical Prescribing (NMPs) in Community Services to prescribe for patients under their care.
- Community adult services had a number of nurses (NMPs) that could prescribe and adjust doses for certain medications for patients. Prescribing was within the Nurse Prescribers Formulary, within their scope of practice and agreed formularies and guidelines. Nurses had to be registered to receive FP10 prescription pads.

  The trust monitored the service through a yearly "data report". This detailed the volume, location and category of prescriptions prescribed by nurse prescribers and ensured nurses were working within their scope of practice and following appropriate guidance.
- We observed nurses administering medication via a subcutaneous syringe driver following best practice in medicines management.
- Medication audits were undertaken and outcomes monitored. If any issues were raised, then immediate training would be arranged and targeted where needed.

Environment and equipment

- The electronic system for ordering equipment ensured a quick response and a clear audit trail and teams were kept updated regarding any new equipment available.

Requires improvement

Are services safe?

- Teams considered the need for bespoke specialist equipment such as in-bed sleep systems and complex equipment such as profiling beds to enable patient's independence. There was a system in place for servicing beds, hoists and wheelchairs.
- The trust has installed automated external defibrillators (AEDs) for community services and had instigated ongoing training programmes to ensure staff were competent in its use.

Quality of records

- We looked at 24 paper and electronic records. 50% of records we looked at were incomplete.
- On the patient electronic record, 13 patients did not have a care plan scanned onto the system.

  Eight patient's paper records we looked at in their own home had a care plan however there was often very limited current information on the patients care needs. Staff signatures were missing on two care records to say they had delivered the care. One care plan had eight "problems" recorded however seven were about following infection control processes and one about wound care. The action recorded was to "follow the plan", which was not written down in the care plan. Feedback from one patient expressed concern that the wound management plan in their paper record care plan in their own home was not being followed.
- Important information such as allergies information was missing off one record. The initial assessment had been completed in April 2016, the MUST and Waterlow were incomplete. The patient was allergic to penicillin and this information had not been recorded on their care plan. The patient told us the GP prescribed penicillin; they had taken the first dose before realising the mistake. Community nursing staff had been visiting the patient for five months and had not been aware this was missing from their records. The patient had medication record in their home as they required regular medication and this information was not recorded on their medication record.
- Records did not always have the patients NHS number. For example one record had an assessment completed in August 2015 and the NHS number was not written on any of the paper records, including the care plan.
- The consent to the care plan was not signed by the patient and written nursing notes were not concurrent, which meant that it was difficult to know what the treatment plan was and whether it was being followed. Written care records demonstrated nursing staff visited at least once a week since August 2015.The patient was at risk of falls, previously fallen and was being treated for a pressure sore. The skin integrity record, falls and moving and handling assessment were not completed.
- In several other examples we saw similar themes; one patient had an initial assessment in their paper record, completed March 2015, although the patient had a hospital bed, the "pressure relieving equipment in use" form, moving and handling risk assessment and skin integrity check were not completed. In another example the initial assessment had been completed in April 2014. The patient used equipment to enable them to mobilise and were at risk of falls, having previously fallen. The falls screening tool and dependency tool were not completed. Records did not reflect patient's current health conditions and risks and had not been updated. We found similar examples of incomplete records in all the paper records we looked at.
- Falls risk assessments had not been completed for four patients and a further two were incomplete. Two patients had previously been known to fall and risk assessments were not completed
- Moving and handling risk assessments were not completed for six out of eight patients; three of the patients required a wheelchair and assistance to mobilise.
- The malnutrition universal screening tool (MUST) and Waterlow scores on eight paper records were completed however two were not dated two were incorrectly dated for two weeks in advance of our visit. Most patients were scoring over two which was high risk.
- Of the 24 electronic records we looked at most did not have current scanned copies of MUST and Waterlow information so we were unable to determine whether paper records would have been reviewed within the timescale.
- Important data such as recordings of blood pressure, temperature, pulse oximetry and past medical history

were sometimes missing. These omissions meant that staff did not have an accurate baseline recorded from which to measure future changes in patients' health status and to inform decisions about subsequent care.

- Managers said community nursing care plans should be reviewed whenever a change happened and it was up to the nurse to decide when that was. Line managers and nursing staff told us they did not complete any quality auditing of the paper records. One manager said staff know what they need to do, another nurse said it's not until patients are discharged and paperwork returned to the office that they go through and sort them before they are scanned onto the patient's electronic record.
- Senior managers told us they did not complete any local quality audits of paper records.
- The risk team carried out a yearly records audit where five records were reviewed for each team. This was a very small percentage of the community team's caseload. For example; managers said teams had over 300 cases per team, approximately 900 care records across three teams. A small sample of 15 records would not representative and less than 2% of records. This meant we could not be assured the trust had effective arrangements in place to monitor the quality of records.
- Therapy patient records were inputted directly onto the patient's electronic record. We looked at three records and saw they were up to date and all had comprehensive assessments and up to date care plan notes. Staff told us these were sampled by their line managers as part of one to one supervision.
- Trust information stated that staff completed Information governance training as part of mandatory training. Community services were 93% compliant.

Cleanliness, infection control and hygiene

- The overall hand hygiene compliance score for the trust was 98%. We were unable to determine regular hand hygiene compliance rates in community services however we observed two staff following infection control guidelines.
- Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- Community bases and clinic environments we visited were clean and free from clutter. Hand hygiene gels, paper towels and rubbish bins were provided.
- Nursing staff disposed of infected clinical waste in identified bins which were collected from the patient's home.However we observed two sharps boxes in two patient's homes that had not been dated. This meant we were unable to determine how long they had been in use. Nursing staff told us they should be replaced every three months but did not know when they had been first used and had not noticed they were not dated.
- We observed nursing staff following recommended infection control practice in the nursing care of a patient who had a urinary catheter.
- We did not see evidence of infection control audits that were undertaken in the community setting.
- We attended home visits and clinics. In all settings staff used techniques to prevent spread of infection including hand-washing and use of personal protective equipment such as gloves and aprons.
- The trust had reviewed its Infection Prevention and Control Operational Policy in March 2016. infection prevention and control service for community services was provided by the Infection Prevention and Control Nurse for Community Services overseen by the Deputy Director of Infection Prevention and Control.(DDIPC)

Mandatory training

- The trust required staff to make "maximum use "of e-learning to deliver mandatory training. E-learning materials had been developed to meet mandatory training needs and could be accessed electronically. These included, consent, manual handling, safeguarding level one, equality and diversity and information governance.
- Trust policy stated that "protected time should be scheduled to enable staff time to complete the relevant e-leaning". However, minutes of the December 2015 divisional manager meeting highlighted issues with hot-desking, IT and RIO that would make it more difficult for staff to access e-learning and be unable to roll out the software required for e-learning. The trust were looking at ways to manage the issues.

Requires improvement

Are services safe?

- Staff told us hot-desking could be a problem, one said there were "28 staff and they had to share 6 desks". This meant they could not always access a desk when they wanted it to do the e-learning.
- Most staff we spoke with told us it was very difficult to have the time to do the training, nurses told us they often logged in from home to do the training as they were too busy at work. Managers said they knew staff struggled to complete the training and they kept a record of who needed updating but it was up to staff to find the time. One nurse told us they had asked for and received protected time to do their mandatory training but then had problems because elements of the IT system were slow and intranet connection was not always possible. This meant they had not been able to use the time effectively.
- Information provided by the trust stated, 88% of community staff had completed infection control Level 1 and 88% had completed level 2. 93% of community staff had completed information governance training and 89% overall had completed all modules for mandatory training.
- Information governance and equality and diversity training were not included on induction and were e-learning courses. Information was unavailable on targets for training courses or numbers of staff that had completed specific courses.
- Staff in the different teams described good access to mandatory training and nine staff told us they were up to date with mandatory training.

Assessing and responding to patient risk

- Nursing staff were not consistent in their approach to pressure ulcer wound assessment. Risk assessments were not routinely completed on patient's records.
- The National Institute of Health and Care Excellence (NICE) guidelines recommend use of a validated measurement tool such as photography or transparency tracing when assessing wounds. This is because repeat views of a wound can be compared objectively over time. Guidelines used by the trust gave clear instructions regarding use of photography. The electronic patient record system did allow for photographs to be uploaded onto wound care plans; however these were not evident in some of records we checked. This meant that changes to wound presentation were less likely to be accurately recorded and deterioration may not have been identified.
- Due to inconsistencies in record keeping, teams did not always have a clear overview of the patient's medical status over time. This was important when managing patients with complex conditions in community settings who were at risk of deterioration.
- Lead nurses told us assessments were reviewed when there was a change in the patient's condition. However we were unable to confirm this as records were incomplete, risk assessments not always completed and in two examples where MUST had been changed the new score had been written on the previous MUST assessment and not dated. We were unable to correlate what was written in the care plan with the patient's assessment information.
- We found that 50% of records were missing an assessment to identify risk of malnourishment, malnutrition or obesity; over 50% of records were missing an assessment to identify risk of developing a pressure ulcer. Skin integrity risk assessments for patients at risk of pressure ulcers were not completed for 50% of patients.
- Fortnightly pressure ulcer panels reviewed complex cases where pressure ulcers were attributable to the trust.
- Occupational therapy staff undertook moving and handling assessments in patient's homes in order to mitigate the risk of injury to patients and carers through unsafe handling or ineffective transfer technique. However we did not see any written assessments in patient's paper care records we looked at.

Staffing levels and caseload

- The community services risk register identified: "continual difficulties and challenges in maintaining the delivery of safe standards of nursing care due to staffing vacancies and shortage of temporary staffing".
- The Integrated Governance Monitoring Report (IGMR) October - December 2015, stated that the trust community nursing vacancy rate was 22% which was above their target of 5%.

Requires improvement

Are services safe?

- Information provided by the trust stated agency and bank staff use was 16%.In some teams significant numbers of staff were agency or bank. For example in one community team five out of six band 5 staff were agency or bank nurses. Several staff said this meant those staff would not necessarily have the skills necessary to provide specialist care, for example catheter care or syringe driver care and this put more pressure on those members of the team who were trained.
- Nursing staff told us lack of staff meant they were prioritising end of life care, pressure ulcers/sores and medication. Staff identified "lack of time "as one reason why there was an increase in pressure ulcers and patient records not being updated. Nurses were "task focussed and trying to squeeze patients in". Increasing referrals and initiatives around ensuring patients were not admitted to hospital meant an increasing workload and "things could get missed". They said the trust were very proactive in trying to recruit staff and there were no barriers to recruitment.
- Community nurses told us their caseloads were team based. These meant patients were likely to be visited by different community nurses during their treatment meaning there was a lack of continuity of care. Managers said they did their best to make sure that patients who needed the same nurses visiting to ensure continuity and support to the patients and their family was available, however this was not always possible.
- Community nursing staff and managers said they did not use a caseload weighting tool. Community nurses were allocated patients via a "unit system". The seven and half hour day was split into 15 minute time slots (units). The lead nurse allocated work using these timeframes. For example; changing a pressure ulcer dressing could be allocated 4 units. These timeframes did not include travel between patients. Staff told us the system worked well and that if they needed more time on a visit they would do what was needed before they left. Community staff in the integrated community teams reported that they did not always have time to complete holistic assessments and home visits were often task focussed for this reason. The focus was on completing visits which left them little time to reflect on practice.
- Staff told us that they were very busy and this meant they were unable to spend as long as they would have liked with patients. Managers said staff often worked late with most community nurses working an average of an hour extra a day. Staff were paid overtime or time off in lieu for the extra work. Community nurses said they were unlikely to be able to take time off because of the pressure of work.
- All staff told us they would rather work additional time and ensure patients were seen within the trust target timeframes. Over 50% of staff said this meant some patients could have very brief visits and several said things could get missed.
- There was no plan to review team caseloads. This meant that management did not have detailed oversight of the demands on staff and the capacity available in teams.
- Positive recruitment initiatives implemented by the trust had reduced the number of senior clinical vacancies and there was a "rolling advert" for recruiting newly qualified staff nurse posts.
- The trust had developed a "new to the community" course to support newly qualified staff and those new to community nursing. Managers said the course was competency based and "enhanced the skills and confidence" of newly qualified staff

Managing anticipated risks

- Staff contacted patients by phone wherever possible to arrange a first visit, this was so they could assess whether there were any risks to do with the environment and discuss reason for visit. For example staff checked access to the property and whether there were animals at the property.They used the information to prioritise the timeframe for the visit and identify the most appropriate level of staff to visit.
- Staff had a mobile phone to access support whilst out on visits should they need it.
- Staff told us they asked advice of the specialist nursing staff including tissue viability specialists when required.
- There was a lone working policy in place to support staff working out in the community. Staff were aware of the lone working policy and used this consistently.

Requires improvement

Are services safe?

Major incident awareness and training

- There was a business continuity plan regarding major incidents. It identified key contact details and a process for staff to follow.
- At local level community nursing teams told us they had systems in place to make sure people got visits despite bad weather. For example; Patients who did not need to be seen would be telephoned to check their health and welfare.

Requires improvement

Are services effective?

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

Summary

We rated effective as requires improvement because**;**

- Deprivation of Liberty Safeguards were not always understood and mental capacity was not always appropriately assessed and recorded for patients who may lack capacity. Staff were knowledgeable about the need to act in patient's best interest but were not clear about who could consent on the patient's behalf and how this information should be recorded in patients' records.
- Staff did not consistently use outcome measures to monitor patient progress. For example: Key outcome measures such as the Waterlow Assessment of pressure ulcer risk and nutrition scoring.
- Staff were not following the quality standard for nutrition support in adults which required care services to take responsibility for the identification of people at risk of malnutrition and provide nutrition support for everyone who needed it.

However, we also found:

- Staff with specialist skills and knowledge were used by community teams to provide advice or direct support in planning or implementing care. Teams worked together in a coordinated way and mad appropriate referrals on to specialised services to ensure that patients' needs were met.
- Staff used clinical guidelines and protocols to inform their decisions about care and treatment. Services were delivered in line with evidence based practice.
- The service participated in national audits and developed action plans to make improvements. Patients were given a choice of options to manage their pain.

Evidence based care and treatment

- The trust participated in and initiated a number of national and local audits. For example assessment and rehabilitation (ARU) falls management audit and the National Audit of Intermediate care (NAIC).
- There had been an extensive programme of work within the trust to reduce the number and severity of pressure ulcers. This included a rolling action plan that included all actions identified from the investigation of category 3 and 4 pressure ulcers. The action plan was monitored by 'Sign up to Safety' (this is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible). The aim was to reduce avoidable pressure ulcers within the community setting by 50% by June 2018.
- National Institute for Health and Care Excellence (NICE) guidance was used by staff. For example NICE "Medical Technology Guidance 20" "Parafricta bootees and undergarments" to reduce skin breakdown in people at risk. The trust had reviewed their internal practices and were compliant with the guidance. This was to be monitored through audit by the Tissue Viability Nurses.
- Staff told us that to keep up to date they used the trust website, and received regular trust bulletins and emails from managers
- The trust used some relevant best practice and NICE guidance to develop services and care and treatment were delivered. For example; latest guidance on treatment of leg ulcers and diabetes foot health best practice.
- The intranet was available to all staff and contained links to current guidelines, policies and procedures.

Pain relief

- In a multi-disciplinary meeting, professionals discussed options for pain relief including use of a patch to enable a patient to have more sustained relief from pain which would facilitate their independence in activities of daily living.
- The trust had a number of community nurses who were nurse prescribers. This meant they could adjust patient's pain medication prescriptions when it was needed. Ensuring patients received prompt care when they needed it.

- We saw examples of pain relief being considered during home visits and observed a home visit with a palliative care patient where options for pain relief were discussed with the patient and their family.

Nutrition and hydration

- Lead nurses told us they completed malnutrition universal screening tool (MUST) nutrition and hydration assessments when completing a first assessment of patient care.
- The NICE quality standard (QS24. The quality standard for nutrition support in adults) "requires that all care services take responsibility for the identification of people at risk of malnutrition and provide nutrition support for everyone who needs it". The MUST tool recommends that patients at high risk should be monitored and reviewed monthly and low risk three monthly.
- One senior nurse confirmed this and said MUST and Waterlow scores should be reviewed every three months for low risk and every month for high risk patients.Eight patient paper records we looked at were not recorded as reviewed within these timeframes.
- We looked at four discharge paper records and saw that two MUST were incomplete. This meant staff were not following trust guidance in ensuring they completed a full assessment on patients when referred to the service.

Patient outcomes

- Staff did not consistently use outcome measures to monitor and outcome a patient's progress. For example: Key outcome measures such as the Braden Assessment of pressure ulcer risk and nutrition scoring.
- Falls and wound audits were sometimes undertaken however changes were not consistently documented in patient records.
- Between November 2014 and November 2015 SMCS performance data showed the falls prevention service were above the target of 80% for communicating with the patients GP on discharge within the 5 day target. This meant GPs were promptly informed about the outcome of patients care in hospital.

Competent staff

- Some community nursing staff told us they did not have formal managerial and case supervision and this was confirmed by managers. All staff said that if they needed support or to discuss their work they could do this at any time with their line manager and other team members.
- The trust did not have a trust wide management supervision policy that set out the standards expected for staff.
- Managers and some staff said they could request clinical supervision if they wanted it as it was optional. Two community nurses said they did not have time to request it as they were too busy seeing patients.
- Clinical supervision of staff was inconsistent We looked at the clinical supervision policy and saw it referred to "psychological supervision" and was a supportive role for staff. Managers acknowledged that clinical supervision for the nursing staff required further work.
- Managers were not always able to tell us how many nursing staff had had one to one supervision or whether they were up to date.They relied on the relevant responsible line manager to oversee and ensure it was done. One member of staff said that when their line manager had gone on maternity leave for a year no one had taken on the role. Senior Line managers told us they had regular one to one managerial meetings with their line manager. However they confirmed that band five qualified nurses and unqualified nurses did not have supervision or regular one to one meetings with their line manager.
- Therapy staff including agency and bank staff had regular one to one managerial and case supervision, which was recorded and copy kept on file.
- 85% of community staff had received an appraisal however the quality of appraisals was not audited. Staff said they found it useful because objectives were set and staff development planned. All managers said they prioritised completion of appraisals.
- Three community adults' teams we visited all used agency and/or bank staff. We spoke with agency staff that had worked in the community service for over nine months and another for more than three years. They

had not had one to one meetings with their line manager; however one told us they were able to access trust mandatory training to ensure they stayed up to date.

- Mandatory training figures we saw did not differentiate between permanent and agency/bank staff so we were unable to confirm whether all agency/bank staff were able to access training. Staff raised the issue of bank and agency staff competency and the impact that had on distribution of work that meant some nursing staff were not able to fulfil all the tasks that patients needed.
- Community adults nursing service introduced the 'T –Card' colour coding system as a visual aid to indicate patients' main care need. Patients would be allocated wherever possible to staff with the relevant skills to provide the care. The system was used to support the nursing team to plan patient visits and match their requirements to available staff resources for the week ahead.
- Staff told us this system worked well most of the time but staff sickness ,leave and an increase in patients who needed specialist skills meant there were times when they felt very pressured. Managers said they were able to move staff across bases to cover if needed and the system worked well..
- Newly qualified nurses were put on a six week accredited course as an introduction to community nursing. Following the course nurses worked through a competency framework supported by named member of staff. This enabled them to develop the skills and competencies they needed for more autonomous working.
- Competencies were assessed and recorded by the quality and safety nurse in each team.Staff competency checks were made to ensure staff were following infection control practices and best practice guidance when providing care and treatment for patients with for example, blood glucose monitoring, administration of medications, catheter cares, syringe pump management and IV Drugs.
- An induction process was in place for new and agency staff. We spoke with two new staff members in different team's one permanent and one agency member of staff. They found both the trust wide induction and their local team induction useful.
- There was evidence that agency staff competency was checked on recruitment and permanent staff had opportunities for further training.
- All staff said they could access mandatory training and additional specialist training when required. For example: access to managerial and specialist skills and knowledge including post graduate courses. Staff could apply and were supported with time off work for study and adjustments to working patterns if required. Two staff said they were currently completing master's modules/degrees in Leadership as part of their continuing professional development.
- Health care assistants had either completed or were in the process of completing the "Care certificate". This was a requirement for all new staff entering the NHS from April 2015 and aimed to equip health and social care support workers with the knowledge and skills which they needed to provide safe, compassionate care. We spoke with four staff who said they had completed the care certificate.
- The trust encouraged a culture of "lifelong learning" and nursing staff ran locality based updates on clinical procedures to ensure staff were competent in, for example, syringe pump and medical devices training.

Multi-disciplinary working and coordinated care pathways

- Staff in community teams told us they were not often involved in formal multidisciplinary meetings (MDT) unless it was a safeguarding issue and they were involved. They said they regularly spoke on the phone with colleagues in adult social care, staff in care homes and GPs when needed.
- A senior community nurse represented the service at their own locality GP MDT meeting. One nurse told us that they often did not know any of the patients discussed and that was not the purpose of the meeting as they were there to represent the service and improve links with primary care services. They regularly participated in the gold standards framework meetings.
- Staff were able to consult with colleagues and there was a good rapport within the different specialists. For example, specialist nurses were available for staff to consult and gain advice and support from. These included specialists in for example tissue viability,

respiratory and heart failure service. Staff commented that it was easier to discuss individuals when staff were in the office as it made communication quicker.However, some community staff did not feel they were always involved in MDT discussion or invited to meetings for patients in their care.

- We found examples of effective multidisciplinary working both within and across teams. For example, community rapid intensive support(CRISIS) and community prevention of admission(CPAT)team had good links with the community nursing and therapy services. Some staff were based in the same office as community nursing and therapy staff.
- All staff in the integrated community teams. Nursing and therapy staff were committed to working together to meet the individual needs of their patients.

Referral, transfer, discharge and transition

- Between November 2014 and November 2015 Sutton and Merton community service (SMCS) diabetes specialist nursing service performance data showed that no patients had been offered a copy of their care management plan within 14 days. This was significantly below the trust target of 90%. The trust told us IT processes were "required and needed to be embedded" and they had put in place an interim process whereby patients received a copy of the Gp letter which detailed the plan of care. Managers and staff we spoke with were not aware this was the process they should be following. One manager told us that staff vacancies had meant staff were concentrating on seeing patients and there had been some problems with the mechanisms used to collect data that meant it might not be accurate. Systems were being reviewed and recruitment was in progress to fill vacant posts.
- The SWOOP team was a pilot service based at St Helier Hospital that had access to specialist consultants and doctors as well as therapists. Their role was to see people presenting at A&E and to see whether they could be discharged without admission before breaching national A&E waiting times. They could refer patients directly into acute services if needed. The manager said they worked well together and worked collaboratively with community nursing and therapies team to facilitate same day discharge where appropriate. The team could order appropriate equipment to be delivered to the patient's home, for example, specialist beds and they would refer directly to community nursing and/or therapy teams for follow up.
- Referrals to the community nursing services were made via a central administration centre. Referrals could be made for most community services including, community neurotherapy, rehabilitation team, respiratory team, falls prevention service and heart failure service.

Access to information

- Information was available on standard operating procedures and contact details for colleagues within and out of the organisation. This meant that staff could access advice and guidance easily.
- The trust had produced written information for people accessing the community health service. For example; information was available on healthy eating. Written leaflets could be requested, when required, in a different language or format.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff explained procedures for gaining consent from patients before providing care and treatment. Staff were confident about seeking consent from patients but not confident about what process they should follow. For example; one member of staff told us that if the care home or social services had completed best interest decision paperwork then they would assume that meant they had consent. They were not aware and did not understand that decisions to provide care and treatment were decision specific therefore they could not use someone else's paperwork to assume consent.
- Community nursing managers told us they each had over 300 allocated cases per team and some patients would have health conditions that meant they might have fluctuating capacity or be unable to consent. Over 50% of staff we spoke with said they had never completed the trusts best interest paperwork because there was no need. One told us it could not be completed online and they had to print a copy and complete it manually which all took time. Several staff did not know where to find the form and said they never used it.

Requires improvement

Are services effective?

- Staff said they would consult other family members if concerned and do what was in the best interest for the patient. They told us they did not record them as best interest decisions on trust paperwork or record them on the electronic patient record.
- Discussion at the vulnerable adults working group (December 2015) highlighted similar issues and confirmed what staff told us. For example: "staff have anxiety over MCA (Mental Capacity Act) they escalate to the GP when it's a best interest as it is very difficult and also takes a long time to assess and the Community Nurses are very stretched and don't have the time". Whilst it had been noted in the minutes there was no action plan in place and it was not on the community risk register.
- Nursing and therapy staff in the integrated community teams and specialist services showed awareness of the need for mental capacity assessments to take place but said they would discuss with other clinicians such as the GP, mental health teams or social workers to complete the assessments.
- We looked at the patient electronic record (PER) of 13 patients. 70% did not have consent for care recorded. Three records had identified a preference as to who information could be shared with. Staff told us consent to care information would be written on the patients paper records in their own home. We looked at eight paper records in patients own home. Consent had not been signed by patients in six out of eight records. Trust policy on consent stated that patients must give consent to treatment and this must be recorded on their records.
- Staff received Safeguarding Adults training as part of their mandatory training, however Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLs) was not mandatory and staff needed to request it.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Patients received a caring service from staff that were kind and respectful toward them.
- Both nursing and therapy staff treated patients with dignity, involved patients and their families in their direct care and supported them during times of crisis.
- Few of the records we looked at documented whether people had been involved or encouraged to be partners in their care when assessing their emotional needs
- However we found that in discussions with staff they gave examples and referred to practice that demonstrated they had considered the patients emotional needs although this was not always well documented.

Compassionate care

- We spoke with 12 patients and most were very happy with the care they received. One patient commented that staff were "kind and treated them compassionately". Other patients described being "very happy with the service received"
- Staff in handover meetings demonstrated knowledge, skill and a caring attitude towards patients during their discussions.
- We observed clerical staff in clinics assisted patients promptly and were friendly and efficient.
- We observed staff greeting patients in a friendly, but appropriate mannerOne patient told us staff were" very kind".
- We saw comment cards from people. They were positive highlighting the care, kindness and friendliness of staff.
- The NHS Friends and Family Test (FFT) helps service providers and commissioners understand whether their patients are happy with the service provided, or where improvements were needed.The trust received 1838 responses for community adult services between April 2015 and 31st December 2015. The trust data included Sutton and Merton community services combined. Separate information was not available for Sutton community adult services. 93% of patients said they would recommend the service to friends and family.
- Feedback from patient surveys were generally positive.88% of patients were positive about their care. Overall themes for improvement included, extending opening hours to meet client needs, providing allocated visiting times for community nursing patients and allocating named professionals that each patient sees at each visit. Patients said the service was good and staff listened to their concerns, they felt at ease and "treated as a person and not just a number".

Understanding and involvement of patients and those close to them

- We saw staff took time to ensure that patients understood their care and treatment and were involved in making decisions. For example, we saw staff explaining to a carer why they were going to take a wound swab from a patient and why.
- Written information was available to patients about their care and treatment and medical conditions. These could be requested in a different language when required.
- Patients were able to raise concerns and comments when they had their initial assessment meeting.
- Staff supported patients to manage their own health care and maximise their independence. For example, we observed a nurse talking to a patient and giving practical advice to increase their mobility. Staff in the Podiatry foot clinic gave verbal and written advice to patients.
- The unplanned care and Crisis teams completed holistic assessments with patients to ensure their care needs. Two patients told us they felt listened too and their needs recorded.

Emotional support

- During our visit we observed the community nurses providing emotional support to people and

Good

Are services caring?

relatives.They spoke calmly, listened to what was said and responded appropriately. Two patients said staff "listened" to what they wanted and staff understood their needs.

- Managers told us they ensured that patients were supported emotionally with active signposting to local volunteer sector organisations such as UPLIFT. This was a free service for people living in Sutton experiencing emotional or psychological difficulties).The service was a partnership between the NHS and local voluntary sector organisations and was launched in July 2015.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The services provided a range of specialist therapeutic interventions.
- The trust was aware of the diverse needs of the people who used the service and they provided a range of support as required.
- The trust worked closely with commissioners, local authorities, people who use services, primary care services and other local providers to ensure it understood the needs of the population it served in order to plan and deliver services.
- Staff considered the needs of people who may have difficulty accessing services and adapted their care approach to show respect for cultural factors. There was evidence of learning from the complaints received from patients and families.
- Patients reported that they were satisfied with how to make a complaint and how they were dealt with.

Planning and delivering services which meet people's needs

- The integrated community teams offered a range of services dedicated to treating patients needs that included prevention of admission and the Crisis intensive discharge service as part of the "unplanned" care pathway. The services were able to provide a range of different treatments and therapeutic interventions including rehabilitation therapies and intensive home support.
- The trust worked closely with commissioners, local authorities, people who used services, primary care services and other local providers to ensure it understood the needs of the population it served in order to plan and deliver services.
- The Wellness and Self-Care pathway was launched in December 2015. This provided information on health and wellbeing and support to help patients make the right choices.
- The trust website stated that it provided Diabetes and COPD self-care: nationally recognised online courses, condition-specific classroom-based self-care courses, basic and advanced awareness raising resources, decision aids and support network information.

Equality and diversity

- The trust had a commitment to ensuring a positive culture relating to equality, diversity and inclusion throughout the organisation.
- Throughout community services we found that people's diversity needs and human rights were respected.
- Staff we spoke with were able to demonstrate their understanding of equality and diversity.
- Patient information and leaflets including letters to patients could be provided in a person's own language, large print for people with visual impairment or in easy read versions.

Meeting the needs of people in vulnerable circumstances

- The trust had developed an action plan which detailed timescales for ensuring they met current legislation and good practice guidance. Some had been achieved however they had not met their target to provide "Learning Disability awareness training to Community Services Locality bases" in 2015. This had been delayed and planned to start in 2016.
- Staff demonstrated some awareness of the needs of patients with a learning disability. One nurse said they would see patients in their own home wherever possible and highlighted the need to ensure they communicated appropriately and patients were supported with a carer or family member.
- Staff were aware of the communication needs of patients with dementia. The trust had rolled out dementia awareness training for staff. One nurse explained how they had supported a patient with dementia to stay in their own home. They had involved other relevant professionals to help support the family to provide care and support that was needed to stay in their own home.

Good

Are services responsive to people's needs?

- The Trust had contractual arrangements in place for telephone interpreting and face-to-face interpreting. Patients that required written information in languages other than English could contact the patient advice and liaison service (PALS) help centre for advice.
- Staff had access to interpreting and translation services and could arrange both face to face and telephone interpreting services as required

Access to the right care at the right time

- Between November 2014 and November 2015 the Sutton Merton community service (SMCS) performance dashboard identified that 65% of falls service home response referrals were achieved within the two week target and 78% within the ten week target. This was below the trust target of 90%.
- The community night nursing team were available from 6.30pm to 7am. Referrals could be made Monday to Friday between 8am and 6pm and out of hours and telephone referrals from the 111 service were accepted at other times.
- Between November 2014 and November 2015, SMCS community nursing teams completed all urgent (within 4 hours)and routine assessments (48 hours) within the trust timeframe and were above the 95% target set by the trust.
- Between November 2014 and November 2015, SMCS The continence, dietetics and speech and language service (SALT)were above the 90% target set by the trust for seeing patients within their respective urgent, priority and routine referral timeframes.
- In December 2015 community podiatry services, referral to treat (RTT), average waiting time for first appointments was 5 weeks. Patients were seen within the RTT timeframe of 18 weeks for non –urgent appointments.
- Between November 2014 and November 2015, SMCS Rapid response were performing above the referrals targets set by the trust. For example; responding to referrals that prevent hospital admission, achieving overall 91% against a target of 61% for the year. The rapid response team at St Helier hospital accepted internal referrals from within the acute hospital and linked in with community, social services and voluntary agencies to reduce the risk of admission.
- Services such as community prevention of admission team (CPAT), completed a comprehensive holistic assessment of all referred patients within two to14 hours and then could refer on to the appropriate community and social services, liaise with referrer and patients GP on the outcome of the CPAT review. The team were available to contact Monday to Friday from 8am to 7pm, Saturday and Sunday from 10am-6pm via the telephone.
- The Crisis (community raid and intensive support integrated service) focus was on preventing attendance and admission to A&E and provision of intensive discharge support for people at home and within intermediate care bedded facilities.
- Staff and patients told us that equipment was delivered promptly and they had no problems in getting equipment when they needed it. However feedback from two patients we spoke with was that whilst they always got a visit on the day it was arranged they were frustrated that they never knew what time the nurse would arrive.

Learning from complaints and concerns

- The Trust received 118 complaints in 2015, which covered both acute and community services, of which 117 had since been closed. 8% were re-opened. We were not provided with separate specific data for the community service. Of the 117 closed complaints, 39 were upheld, 66 were partly upheld and 12 were not upheld. The most common themes were communication, appointment delays and cancellation and attitude of staff.
- We saw a report on the effectiveness of complaints handling at The Royal Marsden NHS Foundation Trust dated January 2016. This report detailed the results of a survey of 38 service users who responded between January 2014 and June 2015.The trust contacted complainants to request their views and suggestions in order to improve the overall process. Recommendations included: ensuring information on how to make a complaint was displayed prominently and to create a complaints poster. The action plan detailed the timescales for completion which were January and April

Good

Are services responsive to people's needs?

2016. This meant the trust were actively listening to patients and had a plan in place to improve the patients experience when making a complaint. Patients we spoke with said they knew how to make a complaint.

- Staff said they referred complaints to the Patient Advice and Liaison Service (PALS) if they were unable to resolve the issue locally. Staff supported people, their relatives or carers to make complaints as required. Staff told us they received feedback and shared lessons learnt from complaints if they were about themselves or the team. Those teams that had regular team meeting's said complaints were discussed and discussion took place on the learning and any changes that needed to be made.

Requires improvement

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

- The arrangements for governance and quality performance did not always operate effectively. Not all risks and issues were known and those that were known were not always recorded.
- The approach to service delivery and improvement was sometimes reactive and improvements were not always identified or action taken. This meant the impact on the quality of care for patients was not always effectively monitored.
- Operational organisational processes impacted on continuity of care. We were not assured systems and processes were in place to effectively identify risks to patient care.

However, we also found:

- Leaders encouraged and supported staff so they felt respected valued and supported.

Service vision and strategy

- Managers had a clear vision for their service highlighting their intention to integrate services within generic teams as much as was practical to ensure a seamless service for patients. They spoke of the challenges of working within service level agreements across a range of different commissioners.
- Some staff did not feel connected to the board; one told us they knew who they were however they did not feel they knew what the “vision or direction of the trust” was for community services.Managers were more connected but the trust values were not well known amongst frontline staff.
- The leadership were aware of the need to “try and improve and embed the trust vision and strategy” in community services. They had organised staff "open events" led by a member of the executive team to ensure they were more visible to staff. Most nursing staff told us it was difficult to arrange to attend these events due to work pressures. One member of staff said they had attended and found it very useful.
- The quality and performance report in May 2015 acknowledged that ‘well led’ was a challenge particularly in terms of staff not understanding trust wide strategy plans or governance structures.

Governance, risk management and quality measurement

- Quality of care delivery in community nursing due to current staffing vacancies was highlighted as a risk on the community services risk register. It had last been reviewed in March 2015 and a plan put in place to monitor vacancies and upskill staff.
- The risk team carried out a yearly records audit where five records were reviewed for each team. This was a very small percentage of the community team’s caseload. For example; managers said teams had over 300 cases per team, approximately 900 care records across three teams. A small sample of 15 records would not representative and less than 2% of records. This meant we could not be assured the trust had effective arrangements in place to monitor the quality of records.
- There was a Trust wide action plan in place for pressure ulcers maintained by the risk management team and submitted to IGRM on a bi-annual basis. Themes from the pressure ulcer panel included issues around reporting & communication – duty of candour, education of staff and completion of patient’s documentation as requiring improvement. Managers and staff confirmed they had no regular audit systems in place to review the quality of documentation. This meant they could not be assured staff were following trust documentation standards. For example ensuring that consent was signed and dated by the patient or, where appropriate, representative.
- We looked at the March 2015 to March 2016 Performance information Pressure ulcer risk assessment (PURA) that had been prepared for the two weekly pressure ulcer panel. Monthly percentages of pressure ulcer risk assessments were not completed by individual teams.

Requires improvement

Are services well-led?

- Referrals where a first appointment had taken place and reviews were due showed that for one team for three months between November 2015 and January2016 , 74%, 63%, 64% respectively of PU risk assessments were not reviewed. Tissue viability nurses were recruited to locality teams and their role was to support staff with training and advice and ensure reviews took place when they were due and recorded on the patients electronic record. Staff told us they tried to keep up to date with paperwork but that pressure of work meant delays occurred. One member of staff said "staffing and time pressures is the reason why nursing staff were not completing paperwork".
- The February 2016 minutes of the Safeguarding Children and Adults Meeting recorded community adults team would be undertaking audits for safeguarding, with a completion date of April 2016. These had not taken place due to staff vacancies.The trust told us a decision had been made to delay until later in the year to allow teams time to re-establish post-split with Merton however this was not recorded on the minutes.
- The Trust monitored safety and assured quality of service through the monthly and annual "quality account" (QA) report to the trust board. Community services provided monthly performance reports showing agreed performance targets for access to services for patients with urgent and routine needs against the service level agreements.
- The community services division commissioned an external provider to deliver an audit module for 2015-16 to ensure a range of audit tools were available for all services. The web-based platform would "allow for local and division-wide compilation and reporting of audit results which will facilitate action planning". However staff and managers told us this had not been fully implemented and was still work in progress.
- Information was not available from managers about any local audits the community adult service had undertaken over the previous twelve months; however the IGRM noted that no adult community service audits were reported from October 2014 to December 2015.
- Community services undertook clinical audit as part of the trust wide strategic and co-ordinated approach to service improvement. Participation in national audits included the Sentinel Stroke National Audit Plan (SSNAP), Audit of Intermediate Care 2014, and National Audit for Diabetic Eye Screening Programme compliance.

Leadership of this service

- In all of the teams we visited we found that most staff felt proud of working for the trust and were positive about their work. Managers spoke openly about the challenges with recent restructuring in community services and were positive about their ability to fully support the trust to improve the quality of services.
- Local leadership was praised by staff as visible, accessible and responsive.
- Staff's morale within the trust was mostly positive. For example, one staff said they, "Really enjoyed working here," and another said they felt, "Listened to and supported." However some other staff said they were not listened too and did not feel community services were valued by the trust.
- Most staff said the trust was "open to new ideas" and staff input was valued.
- Senior managers saw their line manager regularly. Staff told us that they felt supported by colleagues and managers.
- Leadership events were publicised at team meetings and all staff encouraged to attend.

Culture within this service

- Staff shared their views about the service openly and constructively. They were caring and passionate about the service and the care they provided to patients. Staff felt they worked well together as a team and staff morale was high. Three staff in one office commented there was a "great culture in their office and it "feels like a family".
- Administrators told us they felt part of the team and supported nurses with telephone messages or patient contact. Nursing staff reported that the administrator roles were essential for the team in managing the volume of referrals and ensuring phone calls were answered.
- Staff told us about the negative effects of staff shortages in some teams and this had affected morale at times.

Requires improvement

Are services well-led?

They regularly worked over their contracted hours or felt the care they could offer was compromised at times. Staff were confident that the trust knew about the problems and were doing their best to recruit more staff as soon as they could.

- Provision of protected time for supervision is considered best practice in healthcare. Managers were not able to provide clear oversight of the frequency or quality of supervision of staff which raised concerns around the prioritisation of this support mechanism. Staff records in the integrated community teams showed an absence for some staff and for others inconsistencies in the recording of supervision.

Public engagement

- Community adults nursing staff told us they do not give patients written feedback forms. One manager said staff will telephone a selection of patients and get verbal feedback. Information on how patients were selected was unavailable.
- There were examples of patients being involved in service development. These included patient survey feedback and learning from complaints. In team bases we visited we saw compliments cards expressing patient's satisfaction with the service.
- 97% of community clients would recommend the Trust against a national average of 95% these results were examined and reviewed by the Trust's Patient Experience and Quality Account Group which is jointly chaired by the Deputy Chief Nurse and a Trust governor. The group has a membership of Trust governors, Healthwatch representatives, Patient and Carer Advisory Group representatives alongside representatives from the Trust's clinical staff.
- New Community Services publications include Wellness and self-care for people with long-term conditions.
- There was limited publicly available information about community services provided by the trust on their website. The trust were in the process of updating information after the separation of Merton community services on the 1st April 2106.

Staff engagement

- 95% of staff would recommend the trust to friends and family as a pace to receive care or treatment.
- The trust had procedures in place for staff to raise 'whistleblowing' concerns outside of their line management arrangements.
- Some staff felt that there was a disconnect between front line staff and senior managers. They felt community services were not a priority for the trust.
- The majority of staff knew who the chief executive was and who had overall responsibility for their service. One member of staff said they would have no hesitation in contacting the Director of nursing if the needed to as everyone was very approachable.
- Trust regularly sent a newsletter. Staff were encouraged to look at the staff intranet. However, there was a mixed feedback about the newsletter as some community staff told us the newsletter did not often include information about community teams or reflect the value and role of the community services they tended to focus on the acute trust information. One positive example from staff gave an example where they had been commended in the newsletter for length of service and care and dedication.

Innovation, improvement and sustainability

- There was a commitment to continuous improvement and developing a culture of learning and driving improvement through the use of training and sharing information, skills and expertise
- Staff said they were encouraged to develop new ideas and to share ideas with the teams and managers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider had failed to ensure care and treatment was provided with the consent of the relevant person. Staff were not clear about who could consent on the patient's behalf and how this information should be recorded in patients' records Deprivation of Liberty Safeguards were not always understood and mental capacity was not consistently appropriately assessed and recorded for patients who may lack capacity. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider had failed to ensure that their audit and governance systems were effective in relation to community services for adults. This was a breach of regulation 17(1)(2)(a)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014