

Croydon Health Services NHS Trust

RJ6

# Community health services for adults

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RJ6X1	Community Services	Community health services for adults	CR7 7YE







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

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

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

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

Croydon Community Health Service for Adults requires improvement.

We rated the domains Safe and Responsive as Requiring Improvement.

There were not enough Speech And Language Therapy (SALT) staff employed to meet the high number of referrals. The trust had not always conformed to the 18-week waiting time target for patients referred to the Domiciliary SALT team.

Patients suffering from stroke were not always seen by the community therapy team within two days of discharge from hospital. This meant the trust's target of two days had not always been met.

The Community Intermediate Care Service saw only 30% of patients within the trust's target time of 48 hours from referral.

Between 1 April 2014 and 1 March 2015 84 serious incidents reported by community health services for adults. These incidents were all related to pressure ulcers grades three and four. Despite much attention being devoted to pressure sores, the recording of pressure sores by staff still fell short of the trust's guidelines.

Medicines had not always been stored, handled and administered appropriately and safely. The trust's medication policy and procedures had not been followed by staff. The medication incidents in the community service placed patients at risk of harm. A recent medication incident resulted in the disposal of £500 worth of immunisation and other medicines.

There had been ongoing problems with GPs not completing medication request forms appropriately. Patients were potentially exposed to risk due to medicines being delayed.

Staff knew how to respond to possible safeguarding issues. We noted some recent medication incidents had been referred to the safeguarding team.

Currently the cluster five community nursing team had four community matron posts vacant and three of these posts had been vacant for six months. Although the trust was recruiting, it would be some time before new recruits were in post.

Patients received care and treatment in a personalised and holistic way. Staff followed guidelines from the National Institute for Health and Care Excellence (NICE) and other professional bodies.

There was 24 hour community nursing cover seven days a week. The community nurses were involved in the care of patients requiring palliative care. Patients were supported to alleviate their pain appropriately.

There was effective multidisciplinary team (MDT) working within the adult community service as well as with other health and social care providers.

Patients and relatives gave positive feedback of their experiences of the service. They were complimentary about the community staff and found staff caring, compassionate and respectful.

# Summary of findings

## Background to the service

Croydon Community Health Service for Adults operates in and around Croydon, offering a wide range of NHS healthcare treatments to a diverse local community, including homeless people and asylum seekers. They care for patients with a variety of health conditions, including neurological conditions, stroke, diabetes, musculoskeletal disorders, podiatry, sickle cell, thalassemia and terminal illness.

The service provides planned care, rehabilitation following illness or injury, continuing and intensive management of long-term conditions, co-ordination and management of care for people with multiple or complex needs, acute care and health promotion.

The service offers community nursing as well as therapies, rehabilitation and specialist nursing services for people in their own homes and in outpatient and

health centre clinics. There is a Rapid Response Service, which provides intensive nursing and therapy for patients who meet the criteria, to avoid the need for a hospital admission.

We spoke with 27 patients, two relatives and 32 staff, who included consultants, nurses, therapists, clinical specialists, healthcare assistants and support staff. We visited patients in their own homes, observed care and case-tracked the case notes of three patients. We checked electronic and paper versions of care records and patient notes. We reviewed other documentation, which included performance information provided by the trust. We received comments from patients and those close to them, and from people who contacted us to tell us about their experiences.

## Our inspection team

Our inspection team

Chair: Jan Filokowski

Team Leader: Margaret McGlynn

The team included a CQC inspection manager and a variety of specialists including specialist advisors for management and nursing and a community occupational therapist and a paediatric physiotherapist.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

## How we carried out this inspection

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 16th and 19th of June 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and administration staff. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members

and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the services.'

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?

# Summary of findings

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

## What people who use the provider say

People using services spoke highly of the care they received. The feedback from people was very positive with people telling us staff were approachable and reliable.

People using services for homelessness valued the care they were given and felt staff treated them with dignity and respect.

## Good practice

Patients received care and treatment in a personalised and holistic way. Staff followed guidelines from the National Institute for Health and Care Excellence (NICE) and other professional bodies, such as The British Association of Occupational Therapists and The Chartered Society of Physiotherapy.

There was 24 hour community nursing cover seven days a week. The community nurses were involved in the care of patients requiring palliative care. Patients were supported to alleviate their pain appropriately.

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

The provider should ensure

There are insufficient numbers of speech and language therapists to meet the needs of the population.

Medicines are stored, handled and administered appropriately and safely.

Patients suffering from stroke should be seen within 48 hours of discharge from hospital along with patients receiving care from the community intermediate care team.

Considers how it can integrate the hospital and community IT system to enable a shared care record

Croydon Health Services NHS 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

More work was required to strengthen the systems for ensuring patients received safe care. There were too few speech and language therapists and a number of community matron posts remained unfilled. There were also problems with the writing and filling of prescriptions from GPs and the IT system.

The Trust has two IT systems. A new hospital system IT system is used within the hospital and a different one in the community. There are some community adult services that also use another IT system, but this system does not have full community functionality to have a shared care record across acute and community services. This meant some staff were using both an electronic and a paper system.

Medicines had not always been stored, handled and administered appropriately and safely.

The Serious Incidents register showed there had been 84 serious incidents between 01 April 2014 and 01 March 2015, all related to pressure ulcers grades three and four. The trust confirmed that during this period there were 14 grade three and grade four pressure ulcers that were the

responsibility of the trust. The trust had organised a campaign to raise awareness of pressure ulcers but, in spite of this, pressure ulcer information was still not always being collected and recorded fully by staff.

The cluster five community nursing team had four community matron posts vacant, one of which was due to maternity leave.

There had been on-going problems with some GPs not completing medication request forms appropriately. There had been an on-going problem with dressing packs prescribed by some GPs not being delivered on time. Both of these issues had not been resolved.

### Incident reporting, learning and improvement

- There were 84 serious incidents reported by the trust community health services, according to the trust's Serious Incident system. These incidents occurred between 01 April 2014 and 01 March 2015 and were all related to pressure ulcers grades three and four. It was reported that 96% of the pressure ulcers were grade



## Are services safe?

three and 4% were grade four. However, the trust confirmed that during this period there were 14 grade three and grade four pressure ulcers that were the responsibility of the trust.

- Root cause analysis investigations had been undertaken on pressure ulcers that had been reported as serious incidents and lessons were being learnt. However, a recent audit entitled 'The Community Nursing Pressure Ulcer Proforma Audit' (report dated 01 June 2015) showed that there were still areas of non-compliance that needed to be addressed. Compliance with the proforma varied from 68% to 94%. This included documentation and full recording of assessments using the pressure ulcer proforma (PUP), photographic recording of pressure ulcers and recording the on-going review of care plans for long-term patients on community nursing caseloads. The audit reviewed the collection and recording of all information concerning patients' pressure ulcers. It was based on sampling 10 patients' notes from each of the six clusters.
- Actions taken in response to pressure ulcer incidents were reviewed in May 2015. The trust had organised an extensive campaign to raise awareness of pressure ulcer problems with both staff and the general public. There had been an audit of staff awareness of all matters regarding pressure ulcers.
- The associate matron in cluster four reported that all the patients with pressure ulcers that were currently on their caseload had developed pressure ulcers before they were referred to the community team for home visits. Cluster four had 17 patients with pressure ulcers and staff reported patients' pressure ulcers had improved while under their care. Each cluster kept a monthly pressure ulcers risk register, which included patients with grade one pressure ulcers.
- We observed that each member of staff reported the skin integrity of each patient they had visited during the daily handover. We saw staff entered their findings into the electronic records when they returned to base. One health care assistant showed us the documented evidence, which stated that the patient's skin was intact and that the patient was being discharged that day.
- Community nurses confirmed there had been regular reviews of pressure ulcers and, if required, the patient was referred to the trust tissue viability nurse for their specialist assessment and advice. The cluster five

matron confirmed there had been very few community-acquired pressure ulcers in recent months. During our home visits we observed a wound dressing being done on a leg ulcer. We saw the Waterlow scoring tool being used to assess pressure areas. Reviews of pressure ulcers had been regularly carried out and documented.

- There was openness and transparency when things went wrong. Themes from incidents, such as pressure ulcers, were discussed at cluster team meetings, which were held monthly. Trust information was cascaded down to frontline staff.
- Staff said they used the online reporting system to report incidents. They described a range of incidents that they would report, such as pressure ulcers, medication errors and unsafe staffing levels. Staff confirmed they had received an automatic response when an incident was submitted and that the designated manager had responded within two to three weeks to update the member of staff who had reported the incident. Staff told us senior managers acted upon concerns when they had been escalated.
- Line managers told us staff were confident with using the online reporting system. However, we found that a medication incident, in which a patient's medicines were delayed by two hours, had not been reported. This happened over a weekend where there was a shortage of experienced staff.

### Safeguarding

- The trust's safeguarding vulnerable adults policy and procedures were accessible to all staff. There were key named persons, specialist safeguarding advisors and safeguarding leads within the community teams, together with key contact numbers available to all staff. Staff were aware of this information.
- Staff knew how to respond to possible safeguarding issues. They were able to describe what constituted abuse, the types of abuse that could occur and the procedures to follow if abuse was alleged or suspected. Staff told us they felt confident about reporting concerns about safeguarding.
- Safeguarding procedures and incidents had been discussed at team meetings. We noted some recent medication incidents had been referred to the safeguarding team.

# Are services safe?

- Training in safeguarding vulnerable adults was included in the trust's mandatory training programme. Staff we spoke with said they had completed training in safeguarding vulnerable adults and children to the required level for their role and responsibility; managers and clinical staff had completed level three, all community nurses, therapists and healthcare assistants had completed level two and receptionists and other support staff had completed level one.
- The trust worked in partnership with statutory agencies such as the local authorities and police to safeguard vulnerable adults.

## Medicines

- Medicines had not always been stored, handled and administered appropriately and safely. The trust's medication policy and procedures had not been followed by staff.
- Between 07 April 2015 and 08 June 2015 there were nine medication incidents reported in the community service. Two of these were reported by the trust representative who conducted the 'Safe and Secure Handling of Medicines' audit in March 2015. It was reported that in two community clinics, Waddon Clinic and Woodside Clinic, the medicines storage cupboards were found unlocked and there were some medicines found that were out of date, some being five years old. In one of the clinics, the pharmacy order paperwork was not available.
- Medication administration errors happened in cluster one, cluster three, cluster four and cluster five. In one medication error (cluster one), the syringe driver was set up with the wrong dose of medicine. The patient suffered no permanent effect. There was confusion over the administration of an injection involving the GP, a care worker from a third party provider and the community nurse (cluster three). A nurse (cluster four) administered a wrong dose of injection to a patient. A nurse (cluster five), gave a patient insulin that was prescribed for another family member.
- At Parkway Health Centre (cluster five), some medicines were given twice to a patient due to confusion between the community team and a third party provider. Following a hospital discharge, a patient had been given the same medicines twice over, once during a home visit by a care worker from a private care agency and again

by a community nurse. The medicine in use was taken from two separate blister packs, one a pre-hospital pack and the other a hospital supplied pack. The cluster matron said arrangements had since been made with the care agency to ensure a similar incident did not occur again.

- We were told an incident had been reported through Datix when the fridge at the Rainbow Health Centre was faulty over a weekend; the temperature recorded was out of range but had not been reported promptly until a member of the nursing staff noticed the error after the weekend. They contacted the pharmacy and the manufacturer of immunisation vaccines. On their advice, £500 worth of drugs and vaccines had been appropriately disposed of. As a result of this incident, a new process was introduced; the fridge temperature had since been recorded twice every twenty-four hours and, in addition, the pharmacist carried out spot checks. The incident had been reported and investigated and lessons had been learnt.
- Community nurses used appropriate forms for documenting and administering medicines, such as the trust's 'medication chart for the authorisation and administration of medicines by nursing staff' when they administered medication to patients they visited.
- Staff at the Waddon Centre said they usually gave patients their medicines on time during home visits. However, we were told of an incident one weekend when there had been a delay of two hours in giving a patient their medicines. This was due to a heavy caseload, a reduced staffing level and a skill mix issue, specifically, that an HCA was unable to give medicines, as they had not yet been trained to administer medicines. We were told such an occurrence was rare. The incident had not been reported on Datix.
- Community nurses said they had turned up at patients' homes and found wound dressings had either not been prescribed or had not been delivered to the patient's home on time. We were told one patient had waited three weeks before receiving the prescribed dressings, since the initial visit by the community nurse. Another patient had waited two weeks after the prescription had been requested. To avoid cancelling the scheduled visits, the nurses had been using the spare packs they kept in their cars, which were funded by the trust. When the nurses returned to base, they followed up each case

## Are services safe?

with the pharmacy and the GP practice to find out where the problem lay. This was additional work for the community nurses who had repeatedly reported the situation to their managers but the on-going problem had yet to be resolved.

- There had been on-going problems with instructions contained in medication administration request forms. GPs faxed these forms through so community nurses could administer prescribed medicines to patients at home. We were told by community nurses that it was a frequent occurrence for some GPs to fail to fill in the forms correctly. Nursing staff had repeatedly reported this problem to their managers but the issue had yet to be resolved with the GPs concerned.
- During an unannounced inspection, we were shown an incomplete medication administration request form for a home visit. The GP wrote, 'to administer (insulin name given) and blood glucose monitoring' to a new patient before their evening meal. The insulin dosage had not been specified on the form. The form had been faxed through to the Single Point of Admission (SPA) centre and triaged to the community nurses at Waddon Clinic at 12:57 hours on 30 June 2015. The associate matron contacted the GP surgery as soon as the fax was received; the GP had still not responded to the request by 16:45 hours. This meant the patient had to be contacted a second time to explain the possible delay; the GP had to be contacted again and the visit had to be rearranged with the Out of Hours nursing team, so that they could visit the patient the same evening, before the patient had their evening meal. This delay potentially exposed the diabetic patient to risk of harm.
- We checked the medication storage facilities including the storage cupboard for controlled drugs in one of the health centres, Coldharbour Health Centre. The drug cupboards were locked and medicines were in date and there were no controlled drugs in stock. Staff confirmed there were no controlled drugs in use at the present time.

### Environment and equipment

- Patients were seen in a variety of settings within the adult community service. On the whole, the environment was clean and reasonably tidy but

cluttered in some areas. Some community clinics were held in buildings with limited space and the layout and facilities were not as suitable as the more modern community health centres.

- For example, at the Parkway Health Centre, the office environment was not as spacious as others and often there were between 22-28 staff present. The problem had yet to be resolved but, there was a Croydon Council led regeneration plan in progress for Parkway which would include new health facilities.
- Staff working in health centres and clinics knew how to report faults or request maintenance of equipment they used. All equipment used in clinics had been checked and a checklist completed. All equipment had a portable appliance testing label that was in date. Blood glucose machines in use were routinely checked. There had been no concerns raised about equipment not being available when needed to treat patients.
- Community nurses visiting people in their own homes told us they had adequate supplies of sterile wound dressing packs to carry out dressings on patients' wounds. However, staff said there had been an on-going problem with the ordering and delivery of prescribed dressings via local GPs and the supplying pharmacy.

### Records systems and management

- We were told some community centres had yet to transfer to the new electronic patient records system. For example, staff at the Waddon centre continued to use the existing IT system to update their electronic records. Paper recording also remained in use.
- Community staff told us that there were challenges with implementing the electronic patient record system for the community. One member of staff commented that the system did not always generate an accurate report. For example, when three members of staff of different disciplines visited a patient at the same time, the system was unable to generate the information accurately. The staff had since kept paper records to reflect the names of staff and the date and times of their visits so that accurate records were maintained, until the issue could be sorted out. Staff had reported the incident.

## Are services safe?

- Since the inspection the trust has clarified that these services are not planned to transfer to the hospital IT system as it does not have the required functionality. The issue is how the trust integrates the hospital and community systems to enable a shared care record.
- All patients' records were securely locked in cabinets in the community staff office. There were key-coded locks on the office door for additional security and electronic records were protected by password access.
- There were systems and protocols for sharing information with other healthcare professionals, such as GPs and medical staff from other NHS trusts.
- Staff could describe how people's confidentiality was protected. There had been no incidents of breach of confidentiality in regard to patients' records.
- Information governance was included in the mandatory training programme for staff. The training highlighted awareness of how breaches of confidentiality and unwanted disclosure of confidential information could be prevented.
- Staff showed us patients' notes, including paper and electronic records covering assessments, planned needs and the daily nursing care provided. Both nurses and therapists said they had documented the care provided on each visit in the paper-based record folder kept in the patient's home and had also summarised and updated the electronic version when they returned to base. We saw evidence of these documents both on paper and electronically and they had been updated appropriately.
- Infection control and hygiene measures were taken with each patient seen. We observed staff washing their hands and using antibacterial hand rub in-between contact with patients and on entering or leaving an area.
- Appropriate infection control practices were adhered to. Staff working in clinics, health centres and patients' homes had demonstrated appropriate hand washing techniques and infection prevention practice to reduce the risk of spreading infection.
- Community nurses wore clean uniforms with arms bare below the elbow, as required by the trust's policy. Personal protective equipment (PPE) was available for use by staff in clinical areas and in patients' homes. Community nurses and therapists were provided with hand hygiene gel to take around with them. We observed community staff wearing PPE such as disposable aprons and gloves when required and using correct techniques for dressing wounds.

### Mandatory training

- The target set by the trust for mandatory training completion was 90%. However, the data supplied did not include a section for community staff.
- Staff confirmed they had access to e-learning and the majority said they had completed mandatory and statutory training and refresher courses such as safeguarding, moving and handling, pressure ulcer management and infection control.

### Assessing and responding to patient risk

- We accompanied some community nursing staff as they visited patients in their homes. We saw evidence that patients had been given individual risk assessments concerning pressure ulcers, falls, nutrition and hydration and pain relief and other risks. During a home visit, a community nurse was observed dressing a leg ulcer and an appropriate wound dressing technique was followed. We noted that the community nurse documented all tasks carried out appropriately in each patient's medical record file, which had been kept up to date. The community nurse updated each patients' electronic records on returning to base.
- On another home visit we accompanied a Speech and Language Therapist who was conducting a follow-up visit to a patient with motor neurone disease. The therapist was thorough in their assessment and

### Cleanliness, infection control and hygiene

- The trust had infection control policies and procedures. These included clinical and general waste disposal and the safe management of sharps.
- Staff were aware of trust policies and procedures and knew where to look for them on the intranet, including the hand hygiene policy and the procedures to follow in the event of needle stick incidents. In April 2015 a member of the nursing team sustained a needle stick incident while assisting a patient. The Sharps Injury procedure was followed appropriately.

## Are services safe?

provided the patient with information and techniques to help improve communication, so that the patient was able to indicate quickly to their carer, for example, if they were in pain or felt uncomfortable or if they urgently needed assistance. The therapist was supportive of both the patient and their spouse.

- Staff were able to obtain equipment for patients if their risk assessment indicated it was required. For example, through the wheelchair service, a patient had recently been provided with a state of the art wheelchair fitted with a speech synthesiser and other equipment. Prior to this, a risk assessment had been done by the appropriate team to ensure the home environment was suitable and the equipment was safe and able to meet the patient's needs. The patient told us the community team had helped them regain their independence and self-confidence.
- In all nursing teams, there was a handover period after the lunch break during which each member gave their feedback regarding the morning visits and the team then worked out the visit list for the afternoon. With the Cluster four team, the routine visit list was done the week before the visits were due but in other centres staff received their cases on the day, during daily handovers.
- We attended the Cluster four handover meeting in Waddon Health Centre. One team was led by the assistant matron and the other by a team leader (RGN Band 6). We saw nurses and healthcare assistants giving their feedback following the morning visits. This was followed by discussion of issues that needed to be addressed urgently before staff continued with their afternoon list of visits. We observed how staff had worked together; for example, when a member of staff had not been able to complete their morning visits, other team members had helped out in the afternoon.
- There was a haematology handover every Monday and the pathology team communicated the blood results to the community team appropriately.

### Staffing levels and caseload

Domiciliary Speech and Language team (SALT) at Broad Green

- The Domiciliary SALT team expressed concern about their staffing numbers. They said there was an increase in the number of referrals and the demand had outweighed the capacity provided by the team.

Increasingly, the type of patients referred had more complex needs, which meant the therapist had to spend an extended time with each patient. They felt the staffing number was insufficient to cope with the increased number of referrals. They had repeatedly raised the staffing issue with senior management but the staffing number had remained the same. Currently there were eight referrals a week.

- The team consisted of 1.9 WTE of SALT therapists (band 6), comprising one full time and two part time therapists and an administrator. The team had a line manager (band 7) who was off-site. The SALT staff were expected to visit, assess, advise and review patients with neurological conditions. One full-time member of staff had 25 patients on their caseload. One part-time therapist, who worked two days a week, had eight patients to see per week. Apart from home visits, the therapist also conducted two community group sessions on alternate weeks at each of two clinics, Sanderstead and Waddon.
- The SALT staff worked together to plan the case loads and referrals and only contacted their manager (band 7) if they had concerns or needed advice. Their line manager was based in the hospital and also managed three other therapy services. The line manager said contact with the team was usually by email or telephone but the whole team met for team meetings, where information was shared and issues were discussed. Staff felt able to discuss issues with their line manager.

The Sickle cell and Thalassaemia Centre

- The sickle cell and thalassaemia service was fully staffed and we were told there was no problem with staffing.

Community Nursing Clusters

- The community nursing teams were divided into six clusters which served the community in the Croydon region. The trust used the national Safer Nursing Care Tool to review nursing staffing levels and each cluster had been assessed against the caseload and the size of the area. Each cluster was managed by a community matron supported by an associate matron. Within each cluster there were either two or three teams of nursing staff, depending on the area covered.



## Are services safe?

- For example, in Cluster four (Waddon Clinic), we met two teams; one team comprised three nurses (band 5s), three HCAs (band 3), one phlebotomist and a team leader/case holder (band 6). The other team comprised two nurses (band 5s) and one healthcare assistant (HCA band 3) and they reported to the associate matron (band 7) during the afternoon handover. We were told one of the band 5 nurses was an agency worker, who had been working in the team for some time.
- The cluster five community nursing team was based at Parkway Health Centre. Cluster five covered a larger area than the other five clusters. There were three teams of nursing staff. Staff said three community matrons had left in the last six months and one was on maternity leave. We were told the trust had advertised and the recruitment process was in progress, with two applicants possibly joining the team in the next few months.
- CICS comprised physiotherapists and occupational therapists who worked together to assist patients in their homes for up to six weeks. Occasionally, CICS might extend the period of care, depending on the progress a patient had made.
- Staff in the South team confirmed they had not managed to see all new patients within 48 hours after referral due to high demand and an insufficient number of qualified therapists to provide cover.
- The South Team employed two occupational therapists (band 6), one physiotherapist (band 6) and one team leader, a physiotherapist (band 7). On a busy day a therapist could see six to seven patients and also carry out a weekly review. Each therapist had 15 patients to review weekly.
- CICS therapists (South team) were supported by six experienced healthcare assistants known as Generic Support Workers (GSW band 3) who carried out daily visits to these patients. GSWs followed the personalised care plans which the therapist worked out with the patients on their caseload. The GSW reported back to the respective therapist any concerns they had. The aim was to assist and support these patients in their rehabilitation and recovery programme to help them achieve an independent lifestyle as soon as possible and to enhance their quality of life. This meant the patients were visited as planned and their needs were being met. We were told one GSW (Band 4) would be starting with the South Team some time in July 2015.

### The Homeless Health Team

- The Homeless Health Team, based at the Rainbow Health Centre, was led by an Advanced Nurse Practitioner (Band 8a). There was input from a locum GP one day a week. The team included three qualified nurses. A specialist midwife was recently recruited to work specifically with the migrant and refugee community. The Homeless Health team had funding to buy in the support of a Mental Health Nurse from the local Mental Health trust as required.

### Rapid Response Team

- The Rapid Response Team consisted of two geriatricians, an occupational therapist, a physiotherapist and two clinicians (band 7 and band 5 nurses) and an SPOA clinician (band 6) with a dual role. The staff were all experienced in their field. They formed part of the Transformation Adult Care Service (TACS) team of 46. The Rapid Response Service provided intensive nursing and therapy for patients who met the criteria, to avoid the need for a hospital admission.
- We were told two locums covered maternity leave in the North team; one occupational therapist (band 6) and one GSW (band 3). However, the recruitment process was in progress to recruit two physiotherapists (band 6), two occupational therapists (band 6) and a GSW (band 4). We were told some new recruits would be working as part of the Rapid Response Team.
- The various therapy teams in the community arranged their own local system of team work. Two therapists working in CICS South Team at the Waddon Centre explained how they planned their daily workload. This included updating the two notice boards in the office every morning, one for existing patients and the other for new patients. For the existing patients, the team would know exactly which member of staff would be visiting a named patient. For the new patients, the team

### Community Intermediate Care Service (CICS)

- CICS comprised two teams, designated as North and South. CICS staff worked closely with the Rapid Response Team and the SPOA. They were all managed by one senior manager (band 8) based at Lennard Road centre.

## Are services safe?

would know who would be assessing a new referral. This avoided having duplicate appointments for the same patient. Whichever therapist carried out the general initial assessment, subsequent visits and reviews would be done by the specialist therapist most appropriate to the patient's therapeutic needs.

### Managing anticipated risks

- Staff were aware of the type of incidents that were considered high risk, such as pressure ulcers, falls and complaints. We found community staff had taken appropriate action to prevent pressure ulcers and to minimise falls for patients through multidisciplinary team working.

### Lone and remote working

- Staff had access to the trust's lone working policy. Community staff said they were provided with personal

alarms but not all staff wore them when working alone. We were told staff had the option to carry or not carry the personal alarm with them when lone working or working remotely.

- We were told the trust had arranged for all community staff to be issued with smart phones which were being rolled out. Some nurses confirmed they had already received them. Staff said they phoned each other and operated a buddying system to ensure each other's safety. Staff told us they worked in pairs when working out of hours.
- We found some staff were aware of the trust's safe word to alert other staff when they were in distress and needed support but not everyone we spoke with knew this.

# 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

Community staff followed guidelines from the National Institute for Health and Care Excellence (NICE). The occupational therapists also followed guidelines from The British Association of Occupational Therapists. Physiotherapists followed professional guidelines from The Chartered Society of Physiotherapy.

The Community Intermediate Care Service (CICS) took part in collecting data for the National Audit of Intermediate Care 2015.

Patients received care and treatment in a personalised and holistic way and their consent was obtained before care and treatment was provided. Patients were supported to alleviate their pain appropriately.

Community staff were appropriately qualified, skilled, experienced and competent to carry out their roles safely and effectively and in line with best practice. New staff received a competency-based induction programme.

We found some staff had varying levels of understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

There was effective multidisciplinary team working in the adult community service and staff worked well with other health and social care providers. The community nurses were involved in the care of patients requiring palliative care.

There was a student placement programme in the community service. A student said they felt welcomed and they were very pleased with the training programme.

## Evidence based care and treatment

- The trust's policies and clinical guidelines were based on the National Institute for Health and Care Excellence (NICE) guidelines. These were held on the trust's intranet and were accessible to all staff, including the community service.

- Community nursing staff had followed the NICE guidelines and had assessed risk using the Waterlow Score tool, the Malnutrition Universal Screening Tool (MUST), the falls tool and others.
- The therapists said they followed professional guidelines from The Chartered Society of Physiotherapy and The British Association of Occupational Therapists.
- There were a number of assessment tools in use by therapists depending on each patient's condition. For example, the Berg Balance Scale was used as the preferred choice to assess patients with mild stroke. The Tinetti Balance Assessment tool was used mainly for patients who had fallen but was not restricted to fallers.
- In the community, care and treatment was planned and delivered in a personalised and holistic way. A designated member of staff carried out an initial assessment. People had care plans that covered their health and social care needs.

## Pain relief

- People using the service were supported to alleviate their pain appropriately. One community nursing team lead (band 6) confirmed they had used syringe pumps to provide pain relief for patients at home. Staff observed the prescribed medicine protocol for pain relief and administering the medicines as prescribed, sometimes through a syringe pump or as an injection. Nurses had been trained to use syringe pumps.

## Nutrition and hydration

- We accompanied a community nurse who was visiting patients with diabetes and who required insulin injections before they had their meals. In the course of these visits, the community nurse prompted each patient to maintain a healthy diet.
- We saw evidence of risk assessments being carried out for all new patients using the Malnutrition Universal Screening Tool (MUST) score. The community nurse



## Are services effective?

demonstrated how the MUST tool was used to assess the patient's nutritional needs. If the nurse had concerns about a patient's nutritional and hydration needs, the patient would be referred to a dietitian via their GP.

- During a follow up visit, we noted the Speech And Language Therapist having a detailed discussion with both the patient and their spouse about the percutaneous endoscopic gastrostomy (PEG) feeding regime and the benefits of having a small amount of oral fluid intake. The patient was advised that if they wished to do this, the therapist would return to assess the situation, as the person had swallowing difficulties.

### Patient outcomes

- CICS staff told us they were involved in collecting data for the National Audit of Intermediate Care 2015. Each therapist had to fill in a 'service user questionnaire' with each patient they had visited during a specified period. The survey was completed at the end of June and the data was submitted for analysis.
- Each community cluster carried out audits on pressure ulcers, blood glucose monitors and record-keeping.
- The Domiciliary Physiotherapy Team had conducted a record-keeping audit every year. In 2014 they were 96.63% compliant.
- We observed good care when we accompanied a community nurse and a therapist on their home visits. The community nurse listened to patients' concerns and helped them to access the correct support, such as contacting social services regarding housing and financial matters. Patients could be referred to specialist clinicians such as the diabetes nurse, or the tissue viability nurse to assess a pressure ulcer, or they could be referred to the wheelchair service. This ensured that patients received the best possible care and treatment to achieve good outcomes.
- During a home visit, we observed a Speech And Language Therapist having an in-depth discussion with a patient and their spouse on oral hygiene, nutrition and hydration, and communication methods. There was a holistic approach to care and the patient and their spouse felt they had been appropriately advised, had

been given a choice, and had been encouraged to make their own decisions. The patient had been encouraged to be largely independent, but to use support when they needed it.

- The community nurses were involved in the care of patients requiring palliative care. The team worked closely with a local hospice consultant, who was responsible for prescribing medicines for syringe pumps, including medicines for pain relief. The community team could also seek advice from the clinical specialist nurse in palliative care at the local hospice. The community staff said they sometimes contacted the Marie Curie nurses to support their patients at night if relatives were not able to stay with them. We were told the trust's hospital palliative care team was not involved with palliative care in the community.

Note: If you have an illness that can't be cured, palliative care makes you as comfortable as possible, by managing your pain and other distressing symptoms. It also involves psychological, social and spiritual support for you and your family or carers.

### Competent staff

- Staff were appropriately qualified, skilled, experienced and competent to carry out their roles safely and effectively and in line with best practice. All the patients we spoke with in clinics and in patients' homes were complimentary about the abilities of the community nursing staff and therapists.
- Staff said that their training needs had been identified in supervision and appraisals. All the staff had access to e-learning and the majority said they had completed mandatory and statutory training and refresher courses such as safeguarding, moving and handling, pressure ulcer management and infection control. Other topics included information governance and resuscitation. Staff were also able to request additional training to enhance their skills.
- Qualified nurses renewed their Nursing and Midwifery Council registration yearly and had maintained their professional standing. Therapists had maintained their professional standing.
- New staff had a competency-based induction programme. This included a corporate induction as well



## Are services effective?

as the opportunity to shadow staff. Different competencies were assessed by a clinical supervisor and they were 'signed off' when they were deemed competent. For example, in the case of nursing staff, the training about catheterisation of patients involved a study day for theory followed by three competency checks covering male, female and pubic catheterisation.

- Members of the Homeless Health Team had a two-week induction programme that covered visits to the Home Office and to other homeless and asylum centres in London, where people received long-term counselling and support. This enhanced staff's knowledge and experience in working with homeless people and refugees.
- There was a student placement programme in the community service. We met one postgraduate student on their second day of a seven-week placement with the CICS south team. The student said they felt welcomed, had been inducted into key aspects of the job and had shadowed the Occupational Therapist on home visits.
- We were told that the Homeless Health Team, based at the Rainbow Health Centre, won the 2015 Nursing Times award for best community student placement.

### Multidisciplinary working and coordinated care pathways

- Staff of all disciplines worked well together. There was effective multidisciplinary team working within the adult community service and within the integrated service, as well as with other health and social care providers. In all multidisciplinary team meetings cases would be discussed individually to consider each patient's medical, nursing, social and therapy needs. A wide range of healthcare professionals had attended these meetings.
- The community matrons and other members of staff said they worked closely with other NHS trusts, GPs, social services and voluntary organisations.
- The care was well co-ordinated to ensure patients had the right care at the right time. We saw that referrals to other agencies and discharge letters to GPs were appropriately completed.
- Within the community service, we saw good examples of collaborative working as we case-tracked the care received by a patient from the time of referral to the

Single Point of Admission (SPOA) through to the Rapid Response Team, the district nursing team, the clinical specialist in tissue viability and the community integrated therapy team, which recently took over the patient's care.

- We were shown the ePEX electronic records system that showed the names of the respective community team of nurses, clinical specialists and therapists, the date of each visit and details of their assessments, reviews and the treatment given. For example, in one set of patient records we noted the patient had been seen by a tissue viability nurse, having developed a grade three pressure sore following a fall and a period of immobility. The patient had since been visited daily by the integrated care team and had been reviewed weekly by the physiotherapist. It was the patient's third review on the day of our inspection. Staff reported the patient's condition was improving and the care plan had since been updated, with the patient's involvement. We were told the patient would be discharged after six weeks when their health condition had improved and they had regained their independence.
- The Adult Community Occupational Therapy (ACOT) team within the service worked closely with the local authority through shared funding to provide occupational therapists to assist patients in their home environment.
- ACOT staff were involved in three different teams. The Intake team worked with the local authority's re-enablement team to provide a six-week rehabilitation programme for patients. The Long Term team saw patients with long-term conditions. The Major Adaptation Unit (MAU) covered the patient's own home environment and any adaptations needed. Staff contacted the housing department and the local authority for equipment and specified the alterations to the home environment needed to meet the patients' needs.

### Discharge, referral and transition arrangements

- Staff working at SPA confirmed referrals had been triaged as soon as they were received. SPA received 120 referrals a day either from hospitals, GPs, the London Ambulance service, the social service and other healthcare providers. These referrals were then triaged

## Are services effective?

to the appropriate nursing and therapy teams across Croydon community services. The SPA also handled calls on behalf of the six clusters of the community nursing service.

- Patients who were referred to the Rapid Response team would be assessed by a clinician nurse (band 7) or a therapist, usually within two hours. If the patient required an overnight admission, but was not serious enough for a hospital admission, the patient would be referred to Barrington Lodge, a private nursing home involved in the Transforming Adult Community Service (TACS) project at which the trust had secured 12 nursing beds.

### **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Some staff had varying levels of understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff confirmed MCA and DoLS were included in the mandatory and statutory

training package (MAST); some staff said the training on these subjects was very limited and some remembered MCA and DoLS were briefly mentioned during the safeguarding training sessions.

- The therapist based at Waddon showed us the staff notice board where information on safeguarding and DoLS was on display. There was also contact information for the safeguarding lead and advisors were also available.
- None of the staff we spoke with had cared for patients in the community who required an application under DoLS. We saw there was a policy and procedure for staff to follow.
- We saw some patient's records where staff had documented that patients had given their consent to care and treatment. A therapist from the integrated team explained how and when a patient's consent was required. We saw a therapy assessment form where consent was obtained before an initial assessment was carried out on a new patient.

# Are services caring?

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

## Summary

All the patients we spoke with in clinics and in patients' homes were complimentary about the staff and the quality of care provided. Patients felt involved in their care planning and found staff very supportive and helpful. Two people said they would like continuity of care by the same member of staff.

The Friends and Family Test for May 2015 for some of the centres we visited showed that more than 95% of patients would recommend the community service to their friends and family.

We observed that community staff interacted well with patients. They were respectful, polite and compassionate.

## Compassionate care

- People we spoke with were complimentary about the staff and the care and treatment they had received.
- We accompanied some community nurses and therapists when they visited people in their homes. We observed good staff interaction with patients. The staff were polite, patient and compassionate.
- We observed a Speech And Language Therapist explaining the various communication methods available and allowing the patient to use an electronic tablet to download information that had been shown to them. The therapist was unhurried and provided clear answers to questions from both the patient and the relative. The patient and their spouse commented, "We have seen the same therapist since referral and we are ever so grateful. Of course, we understand this may not always be possible but so far we have been very lucky. The care is excellent."

## Understanding and involvement of patients and those close to them

- The Friends and Family Test gave good results, indicating that people would recommend the community service. For example, the test result for the Rainbow Health Centre was 94%, Parkway Medical Centre 96%, the Rapid Response team 97% and the CIC team had achieved 100% in May 2015. We were told the

community service had only recently commenced the FFT and the first annual audit was not due till January 2016. Staff were not able to tell us the monthly response rate.

- Recently one patient had requested that the comment card they wrote be shared with the CICS team who cared for the patient. The patient wrote, "Staff were prompt, professional, encouraging, took time to listen and tailored the programme to suit my individual needs. The staff were brilliant." In the Friends and Family Test card section on "How can we improve", the patient wrote "Maybe continuity of staff."
- A patient and spouse expressed how pleased they were to have continuing support. The patient commented, "What an amazing team; whatever we want, they will sort it out for us." The patient's relative told us how supportive the staff had been to both of them.
- A patient and their spouse said they felt reassured following detailed discussions about the patient's care and social needs. Both confirmed their involvement in care planning. The spouse commented, "It was wonderful to have the contact numbers of staff who we could call if we had a question or a problem."

## Emotional support

- In the Sickle cell and Thalassaemia Centre, we noted several 'Thank You' cards on display on the notice board. Patients and their family members valued the integrated service and the continuity of care provided by the community team. We were told that communication had improved between the hospital and the community staff, and that patients had received treatment quickly when they were going through a crisis. Patients had been given green cards to indicate they had the sickle cell or thalassaemia condition. Patients said the community service provided was excellent and they spoke highly of the staff who worked there. Patients said they could phone at any time for advice and support.
- Patients and relatives seen at the Rainbow Health Centre were generally complimentary of the service and

## Are services caring?

the quality of care provided. Patients found the staff very helpful. However, one patient said they would prefer to see the same nurse each time, for continuity of care.

- In the Parkway Health Centre patients and relatives praised the service. Patients found the staff had a

helpful and cheerful attitude and provided them with the information they needed. A relative mentioned that they had been given all the contact details they needed for discussing their relative's case.

# Are services responsive to people's needs?

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

## Summary

The service requires improvement under the Responsive domain because there were issues with waiting times for appointments for some services in the community due to inadequate staffing numbers and increased demand and workload.

Patients suffering from stroke were not always seen by the community therapy team within 48 hours of discharge from hospital.

The Community Intermediate Care Service saw only 30% of patients within the trust's target time of 48 hours from referral.

The community service operated seven days a week with 24 hour cover and served a diverse local population. There were a number of specialist services to meet the needs of the local community, including a nurse-led twilight clinic for patients with sickle cell and thalassemia conditions.

The Rapid Response Service enabled patients to be treated without needing hospital admission.

The Homeless Health Team served people who were homeless and also assisted asylum seekers.

Patients had received personalised care and their health and independence had been promoted.

## Planning and delivering services which meet people's needs

- Generally, there were adequate facilities for patients in health centres where clinics were held, including wheelchair access to toilets. There were clear signs at the entrances to clinics to indicate which clinics were running; the receptionist was available to assist those who needed help. However, some new patients attending the Rainbow Health Centre reported that they had some difficulty finding the clinic that was in session on the day.
- All patients in the Rainbow Health Centre were scanned for TB. There was a mobile unit that visited monthly. We were told the assessment would incorporate HIV tests from July 2015.

- We saw information leaflets on display in health centres and clinic waiting areas. Interpreters were available for people who needed them. Staff knew how to access the interpreting service.
- People had received personalised care and their health and independence had been promoted. During our home visits with the community nurses and therapist, we observed patients receiving appropriate care and treatment and relatives we spoke with felt very well supported.
- Staff delivered care and treatment that focused on people's needs, their preferences and their wishes. The community nurses were involved in the care of patients requiring palliative care.
- Therapists in the community had their own system of working together to provide the best quality care and continuity of care, wherever possible. For example, in the Domiciliary Speech And Language Therapy team, therapists would sometimes see patients with similar conditions, as this was their specialty and area of expertise.

## Sickle cell and Thalassaemia Service

- The nursing team for sickle cell and Thalassaemia patients held a nurse-led twilight clinic for patients with these conditions at least twice a month from 5pm to 7.30pm.
- Patients with sickle cell or thalassaemia conditions benefitted from the integrated care service as these patients would be known to the Accident and Emergency (A&E) Team and all staff would have access to each patient's individual care plan. We were told a member of staff from the A&E team would phone the community team when a patient was seen and admitted to hospital. This had ensured these patients received good, co-ordinated care.

## Community Nursing Clusters

- The community nursing service operated seven days a week with 24 hour cover. Nursing staff worked different shifts such as day shifts (08:30 – 17:00), out of hour shifts



# Are services responsive to people's needs?

(18:00 – 23:00) and night shifts (23:00 – 07:00). During the hour between 17:00 and 18:00, staff from the Rapid Response Team took all the calls until the out of hours team arrived.

- The community nursing staff said they worked well together as a team to ensure all daily visits to patients were completed as planned. There was no waiting list as cases were prioritised daily. Some patients might be visited by the same nurse some days but not all the time; most patients would have met all the team members depending on their care package, the time and frequency of visits.

## Community Intermediate Care Service (CICS)

- The criteria for referral to CICS were that the patient's condition required both physiotherapy and occupational therapy. These could be patients who had loss of fitness due to immobility as a result of hip fractures or falls or patients undergoing rehabilitation programmes. Patients were assisted to improve their mobility and to promote independent function in all aspects of daily life.

## Equality and diversity

- Staff confirmed they had received training on Equality and Diversity and served the local population without any discrimination.
- For example, the Homeless Health Team based at the Rainbow Health Centre ran a healthcare centre for the homeless and asylum-seekers. They liaised with migrant charitable organisations who referred patients to the centre. Some people walked into the centre and temporarily registered for healthcare appointments. Patients and their family members gave very positive feedback about the staff who cared for them.
- Staff were sensitive to people's religious beliefs and they were aware of the procedure to follow in the case of patients who did not wish to have blood products, where this was the only option available.

## Meeting the needs of people in vulnerable circumstances

- People received personalised care in the community. The community nursing service operated a twenty-four hour service, seven days a week, supported by a team of community physiotherapists, occupational therapists and others, such as the SALT team and a range of clinical

specialist nurses and two consultant geriatricians. They worked with 61 GPs in the Croydon area and liaised with social services, the London Ambulance service and the CCG to serve the vulnerable in the community.

- The Transforming Adult Community Services (TACS) was an example of a project set up to meet the needs of the vulnerable client group in the community. TACS was introduced in 2013 and aimed to support people with on-going ill health, to reduce unnecessary emergency admissions and provide high quality, personalised care as close to home as possible. Referrals could be from hospitals, GPs, social services, the London ambulance service and other healthcare providers.
- The TACS project involved the Single Point of Assessment (SPOA) and the Rapid Response Service (RRS). These services were available 24 hours a day, 7 days a week and they were based at Lennard Road Centre, where the out of hours community nurses were also based. The TACS team had been increased to meet the demands on the service and currently had 46 staff.
- The Rapid Response Service provided intensive nursing and therapy for patients who met the criteria, to avoid the need for a hospital admission. The RRS aimed to see patients within two hours following a telephone referral. RRS worked with the intermediate care service to support patients requiring rehabilitation and therapy towards self-independence. TACS had made arrangements with a local nursing care home to provide 12 nursing beds if needed, so that patients who needed support, but not hospital care, could be cared for in a safe way. Up to 31 March 2014, 181 referrals were received by the Rapid Response Service and only 21 were admitted to hospital.
- The Homeless Health Team was set up as a designated service to assist vulnerable and homeless people and asylum-seekers. In 2014, 8,400 people attended the Rainbow Health centre and some had been seen four times. People were all complimentary about the staff working at the centre.

## Access to the right care at the right time

- There were issues with the 18 week referral to treatment target (RTT) for some therapy services due to inadequate staffing numbers and increased demands

# Are services responsive to people's needs?

and workloads. RTT is a performance measure used in the NHS to measure the time taken from when the patient was referred to treatment to the treatment being commenced.

## Domiciliary SALT team (Broad Green)

- Whilst the majority of patients referred were seen by the Domiciliary SALT team before the 18 weeks waiting time target, we found the weekly audit (up to 18 June 2015) showed there were 96 new referrals on the waiting list. We were told eight of the 96 patients had been waiting over 18 weeks. Currently there were approximately eight referrals a week. These patients suffered from neurological conditions. The team of 1.9 WTE of therapy staff, each with their existing caseload, had been unable to give those on the waiting list an appointment at the present time. This meant patients still on the waiting list would have to wait longer and their therapeutic needs might not be addressed appropriately.

## Community stroke and neurological service.

- Patients suffering from stroke were not always seen by the community therapy team within two days of discharge from hospital. The monthly data for April 2015 showed 25 % of patients had not been seen within two days. Therefore the trust's target of two days had not always been met.

## Community Intermediate Care Service (CICS)

- We examined the data from the CICS Waiting Times Audit of compliance with the trust's 48 hour response target, analysed for the period 01 January 2015 to 30 June 2015. This showed that, over this period, 30% of patients were seen (or attempted to be seen) within 48 hours of being referred for treatment. 70% of patients were not seen (or attempted to be seen) within 48 hours, so there was 70% non-compliance with the trust's waiting times target.

## Rapid Response Service

- The Rapid Response Service saw 95.3% of patients within the trust's waiting time target of 2 hours.

## Community Nursing Service

- The community nursing service was divided into six clusters and there was no waiting list in any of the clusters. All the referrals had been prioritised and patients had been allocated to the appropriate team member to visit. Team members would carry out first visits and do their initial assessment. However, new patients with complex needs were initially assessed by the associate matron or the team's lead nurse, who would carry out the first visit before allocating the patient to a team member. This had ensured every patient received appropriate care and treatment. This meant the vast majority of patients were getting a responsive service.

## Learning from complaints and concerns

- Staff said they had access to the trust complaints policy and procedures through the intranet and they felt supported by their line managers when dealing with complaints or concerns raised by patients or family members.
- We noted leaflets and posters on display in health centres and clinics giving details on how to complain about community services. The leaflets contained contact information for the Patient Liaison Service (PALS) and gave advice on how to access help and support. Leaflets were available in different languages.
- Staff working in the community health centres and clinics we visited said they had not been aware of any formal complaints; two therapists from two different health centres said they had been employed for over a year and they had not been aware of any formal complaint about the service they offered. They said any concerns raised had been addressed promptly and this avoided issues escalating to a formal complaint. The team was supported by a therapist manager (band 7) who was hands-on and who conducted weekly team meetings, where caseloads and any concerns arising were discussed and actioned appropriately.



# 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 Trust has a clear statement of vision, values, objectives, safety pledges and promises to patients. There were systems for clinical governance and clear line management arrangements. The managers were generally approachable and supportive.

Staff felt they had been kept informed of trust changes and improvements and that good communication had been established since integration. Staff were committed to providing good quality care and were proud of their work.

The work of the service with vulnerable people, such as homeless people and asylum-seekers, was regarded as a success by staff and something they felt proud of.

Patients and relatives gave positive feedback of their experiences of the service. However, there had been an on-going problem with GPs not completing medication request forms correctly and with dressings prescribed by GPs not being delivered to patients on time. These issues had yet to be resolved.

## Service vision and strategy

- The Trust has a clear statement of vision, values, objectives, safety pledges and promises to patients. The trust's vision was for 'Excellent integrated care for you and your family, when and where you need it'. There were five objectives, namely, 1) To deliver high quality integrated patient centred care which improves outcomes, patient safety and patient experience. 2) To work with partners to improve the health and wellbeing of the people of Croydon, 3) To develop our workforce and to establish a way of working that builds a culture that is committed to an open transparent evidence based approach. 4) To deliver best practice performance standards against the national operating framework. 5) To deliver well managed quality services which are value for money for the tax payer.
- The community service was working towards achieving these objectives. For example, the Transformation of Adult Community Service (TACS) project resulted in the establishment of the Rapid Response Service which

enabled patients to receive highly responsive care across the full range of disciplines in their own homes, avoiding the need for hospital stays, while saving the NHS significant amounts of money.

- Staff confirmed that they had been kept informed of developments at trust level through emails and team meetings at which trust information had been cascaded down.
- Staff were aware of the meaning of the trust's vision and strategy and some members were able to quote the vision statement.

## Governance, risk management and quality measurement

- There was a system for clinical governance. There were monthly quality and safety meetings and other multidisciplinary team meetings where issues were discussed and decisions made to improve care and services.
- Local community teams had regular meetings. For example, the Rapid Response Team held a weekly governance meeting on Mondays led by the Consultant Geriatrician; the meeting discussed cases and matters that arose from the previous week. There was also a monthly multidisciplinary team meeting involving the Clinical Commissioning Group.
- Risks were identified. Weekly risk registers had been kept of patient waiting times and the compliance with target times from referral to treatment. Efforts had been made to mitigate risks, especially risks that might lead to non-compliance with trust and national policy.

## Leadership of this service

- Many staff said they had seen the Chief Executive Officer attending some community centres more than once and they felt able to discuss issues with him.
- There were clear line management arrangements. Staff knew the head of community, the director of nursing and the general managers of the directorate. We were shown the organisation chart, which was on the notice board.

## Are services well-led?

- Some staff felt there remained ‘a gap’ between community teams and senior managers based in the hospital.
- Staff told us their line managers were supportive and approachable. Community matrons and associate matrons were available daily to give support and advice.

### Culture within this service

- Community staff felt the integration service had brought all trust staff together and communication between the hospital and the community had improved. They felt supported by the community consultant geriatricians and managers, who were approachable and supportive.
- The service was open and transparent. Staff felt they had been kept informed of trust changes and improvements.
- Staff had confidence in multidisciplinary working and said they enjoyed working in the community. One therapist commented, “I moved recently to this team. I am very settled and very pleased to be encouraged to go forward in professional development.”

### Public engagement

- Patients and those close to them gave positive feedback about the care and treatment received.

### Staff engagement

- Staff felt that they provided good care and interacted well with patients and the community they served.
- Staff were aware of the Listening into Action (LiA) programme, which elicited feedback from staff on how the service might be improved to benefit the care of

patients. This had resulted in a large number of positive changes in the trust. Listening into Action was a national initiative that put frontline staff in the driving seat of service improvements.

- Staff felt proud to be part of the Homeless Health Team in providing a localised health service to homeless people and asylum-seekers.

### Innovation, improvement and sustainability

- Community staff working in the Rapid Response Service and the Single Point of Admission Service felt particularly proud that the TACS project had been an innovation that had expanded and become sustainable. All the multidisciplinary parties involved, such as the GPs, local authority and the Clinical Commissioning Group, had continued to support the project.
- Since commencement, the Rapid Response Service had evolved and improved; one aspect was to identify patients who were at risk of an acute admission to hospital in the foreseeable future. To achieve this, the community matrons worked as case managers and liaised regularly with GPs, social workers and the community psychiatric nurses to support and educate patients with long-term conditions who had been identified as being at risk of an acute admission to hospital.
- We observed staff’s first ‘away day’ when the team led by the Consultant Geriatrician spent the morning reflecting on what they had achieved so far and how they could improve. The team discussed and reviewed the progress that was made and continued to find innovative ways to improve and sustain the on-going TACS project.

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.

This section is primarily information for the provider

## Enforcement actions

### 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.