Hounslow and Richmond Community Healthcare NHS Trust

RY9

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)
RY9X1	Thames House	Community health services for adults	TW11 8HU

This report describes our judgement of the quality of care provided within this core service by Hounslow and Richmond Community Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Hounslow and Richmond Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Hounslow and Richmond Community Healthcare 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

Data showed there had been an improvement in harm free care. Risk assessment tools assisted community services to respond to identified patient risk. There was good infection control practice in people's homes and premises where patients were treated were clean and hygienic.

At present the high vacancy rates, particularly in community nursing, were impacting on the service. This included placing further pressure on existing permanent staff, a delay in incident investigation, under reporting of incidents, the take up of training and the recording of closed visits on the electronic system. The nursing leadership team were relatively new in post and had made meaningful progress however, staffing remains an area for further improvement.

The trust had recently recruited two practice development leads who had made firm plans and some progress on equipping the nursing service with the right skills to carry out their roles competently. Improvement had been made on rates of clinical supervision within community nursing, which included agency and bank staff.

We found many examples of respectful and compassionate care. We observed nursing staff explain procedures to patients and gain verbal consent to carry out procedures. Staff were respectful and friendly to patients, offering emotional support in all of their interactions we observed.

Community services had a model of integrated community teams across health and social care to ensure people received joined up working. Staff were from diverse backgrounds, reflecting the communities they served.

The number of predicted contacts for community nursing services had been increased for 2015/16 but had already been exceeded with two months left to the year end. Waiting list trends showed a majority of services were meeting targets, however a number of service including podiatry, continence, diabetes and musculoskeletal services were consistently breaching trust targets. The trust was meeting emergency and urgent community nursing referral targets but consistently breached routine targets.

There were clear governance processes and lines of accountability. The community nursing leadership team were all relatively new in post but meaningful progress had been made on improving the quality and sustainability of the service. There were two newly created practice development lead posts. The leads stated clear goals and aims for the coming year.

Staff generally reported a positive culture in community services.

Summary of findings

Background to the service

Community adult services in Hounslow and Richmond are provided by Hounslow and Richmond Community Healthcare NHS Trust. Services were provided in patients' homes or at a variety of health centres and medical centres. Community services for adults includes a range of services including:

- Nine district nursing (DN) teams across the boroughs of Hounslow and Richmond as well as a night service. The DN teams were linked to local GP practices. There were also a number of specialist nurse led services complimenting the DN service such as tissue viability, diabetes and lymphedema.
- Rapid response teams were attached to the local community hospital and local acute hospitals. In Richmond they are called the Richmond Rapid Response Team (RRRT) and in Hounslow Integrated Community Response Service (ICRS). The integrated teams of community health and social care staff provide short term care and support to enable people to remain at home, and regain their confidence and independence. The teams are made up of multi-skilled health professionals including; general practitioners, community nurses, social workers, occupational and physiotherapists, support workers.
- The Community Learning Disability Team provides health and social care to adults who meet eligibility criteria and who live in the London Borough of Hounslow. The multi-disciplinary team includes; clinical psychologists, community nurses, speech and language therapists (SALT), psychiatrists and care managers.
- The musculoskeletal physiotherapy service in Richmond provides specialist physiotherapy assessment, treatment and management advice for patients with a wide range of musculoskeletal conditions including: Neck and back pain, arthritis, joint pain, soft tissue injuries, sports injuries, orthopaedic post-op management, acute and chronic muscular and skeletal conditions, rheumatology conditions.
- Community neuro rehabilitation team (CNRT) is a service for adults with a neurological condition who are living at home. Therapy is delivered to patients in the most appropriate setting, either as an outpatient at Richmond Rehabilitation Unit, or at their home or workplace setting. The services provided by the team include: neuro-physiotherapy, occupational therapy (OT), speech and language therapy (SLT), dietetics, Multiple Sclerosis nursing, Parkinson's nursing, and neuro-psychology
- The Richmond podiatry team were a registered "Any Qualified Provider" (AQP) of routine podiatry care to people registered with a Richmond GP, as well as being the only NHS provider of all specialist podiatry care to people registered with a Richmond GP. The podiatry and foot health service assesses and treats a variety of conditions affecting the foot and lower limb.
- The wheelchair and posture management service team in Hounslow provides wheelchairs or buggies for people who have a permanent disability and a long term need. The team includes, a clinical scientist, therapists, and a rehabilitation engineer.
- We visited the community wheelchair services and the following community teams:
- Learning Disability Service, Hounslow
- Richmond Rapid Response Team (RRRT)
- Hounslow Integrated Community Response Service (ICRS).
- Musculoskeletal Physiotherapy Service, Richmond
- Podiatry, Richmond
- Neuro rehabilitation team, Richmond
- District nursing services and specialist nurse led services in Hounslow and Richmond

Summary of findings

Our inspection team

The team included CQC inspectors and a variety of specialists including specialist nurse practitioners, a doctor, an occupational therapist and a pharmacist.

Why we carried out this inspection

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

How we carried out this inspection

During our inspection, we reviewed information from a wide range of sources that included data supplied by the trust both prior to the inspection and data requested at the time of the inspection. We observed how people were being cared for in their own homes and reviewed care or treatment records of people who use services.

We visited a large sample of community adult services (CAS) and district nursing (DN) across both boroughs. This included physiotherapy, podiatry, district nursing, rehabilitation, wheelchair and rapid response services.

We talked with 17 people who use services and nine carers. We spoke with 42 members of staff including physiotherapists, podiatrists, dieticians, speech and language therapists, occupational therapists, district nurses, junior doctors, GPs, senior professionals, service managers and senior managers.

What people who use the provider say

Patients and carers we spoke with were positive about the care and treatment they received from community adult services.

For example, a person told us, “They are always there, which is very important.” People told us that staff were aware of the emotional aspects of care for patients and provided specialist support for patients where this was needed. A person who used services told us, “I have never felt patronised of talked down to by them.” One patient told us nurses arrived on time, were polite and friendly and always explained everything. On another home visit a patient told us they had the contact details of the management of the service and were aware of how to make a complaint. They told us they had reason to use this contact in order to arrange more support. They felt the service was working well for them and were happy with the process of being able to speak about what they felt unsure about and to have this resolved to their satisfaction.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should further mitigate against the negative effects of short staffing. This includes pressure on existing permanent staff, delays in incident investigation, the under reporting of incidents, the take up of training and the recording of closed visits on the electronic system.

Summary of findings

- The trust should do more to meet its own waiting time targets for services including podiatry, continence, diabetes and musculoskeletal services which were consistently breaching trust targets.

Hounslow and Richmond Community Healthcare 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

'And the completion of electronic records, ending the contact'.

We believe that using the terminology 'recording closed visits' implies patients are no longer on the caseload.

At present the high vacancy rates, particularly in community nursing, were impacting on the service. This included placing further pressure on existing permanent staff, a delay in incident investigation, under reporting of incidents, the take up of training and the completion of electronic records, ending the contact. The nursing leadership team were relatively new in post and had made meaningful progress however, staffing remains an area for further improvement.

The Richmond Rapid Response Team (RRRT) had recently identified a problem with under reporting of safety incidents. Some staff told us they did not routinely record staffing shortages on the electronic incident reporting system.

Data showed there had been an improvement in harm free care such as reported pressure ulcers, falls and catheter and new urinary tract infections (UTIs). Risk assessment tools were in place and assisted community services in responding to identified patient risk. On home visits we observed good infection control practice in people's homes. Premises where patients were treated were clean and hygienic.

Safety performance

- The community adults' service participated in the National Safety Thermometer programme; All community therapy services participated in submitting information. We saw that safety thermometer monthly results were displayed in some of the local offices we visited. For example, the RRRT team's safety thermometer information indicated that the team were 'harm free' in February 2016.

Community nursing

Requires improvement

Are services safe?

- Data showed that between October 2014 and September 2015 there had been a decrease in reported pressure ulcers to an average of around 8 per month for the year. The number of falls had significantly dropped from July 2015 onwards, from an average of 15 to an average of three. The number of catheter and new urinary tract infections (UTIs) significantly dropped from July 2015 onwards, from an average of five to an average of two.
- A service lead told us that national guidance was followed and safety thermometer information was collected monthly. The trust had identified that new and agency staff sometimes made mistakes in inputting data but training was now in place regarding this. Monthly performance meetings to looked reviewed safety thermometer information. DN teams included safety thermometer outcomes at monthly team meetings.
- The safety thermometer quarterly report (October – December 2015) showed data reflecting patients visited in the home or on the trust inpatient unit on the survey date, collected by any team seeing patients over 18 years including nursing and therapy services. It reported a harm free care rate of 94.3% against a target of 95% and 'new' pressure ulcer prevalence rate as static at 1.5%. Over 1500 patients were surveyed.
- The Community Nursing Service Action Plan identified 17 actions that monitored progress on key areas of performance. They included nurse recruitment, staff turnover, agency spend, clinical supervision, medication incidents, safeguarding alerts and pressure ulcer rates. Progress had been regularly monitored and updated. One aim was to 'ensure staffing levels consistently deliver safe and effective community care'. Progress was reported in four areas:
- 1. Number of catheter associated UTIs (CAUTIs), progress was currently stated as: '0.3% green August 2015. The Infection Control team had bid for additional money to work with CAUTIs to ensure one process across the organisation'
- 2. Number of medication incidents, progress was currently stated as: 'Number of incidents recorded in November were 2 Baseline, trajectory and KPI to be finalised. PMO to support as required. Regular monitoring with pharmacy team also diabetes specialist for any insulin reported incidents'.
- 3. Number of safeguarding alerts recorded, progress was currently stated as: 'Service level data on safeguarding alerts not yet received. Additional input and guidance from interim adults safeguarding lead has greatly improved the level and timeliness of involvement in safeguarding cases as required by the service.'
- 4. The rate of pressure ulcer serious incidents i.e. those which are serious and which have developed whilst in our care, per 1,000 patients seen. progress was currently stated as: 'Baseline figure for the service April 14-Jul 15 obtained based on distinct patients seen not activity. Service position against monthly divisional scorecard target for pressure ulcers was green 3.6%. Review of recording and learning and ensuring understanding of the process in place following revision of the SI framework .'

Incident reporting, learning and improvement

- Incidents were reported using an electronic reporting system which also provided reports for managers on reporting activity and incidents. All staff we spoke with were aware of the system and told us they were confident in its use. However, a manager told us the service had recently identified a problem with under reporting of safety incidents in the Response and Rehabilitation Team in Richmond (RRRT). Staff told us the team in Richmond was reporting approximately one third fewer incidents than the ICRS team in Hounslow, but the Richmond team was a larger team. Staff told us the problem had only recently been identified and an action plan was being devised to address this.
- We saw records were kept regarding all safety incidents and near misses reported in community adult services. These included details of the incident and how and why it occurred. We saw that actions to mitigate against the risk of recurrence had been formulated and noted that these were appropriate to the incident described.
- Safety alerts were sent to clinical leads by email. The alerts were reviewed by clinical leads for their relevance and shared with staff by email or discussed at team meetings. Safety alerts were available to staff in team folders on the trust's shared computer drive.
- Some staff told us they did not routinely record staffing shortages on the electronic incident reporting system. The trust monitored safe staffing through a range of tools including the electronic rota system implemented

in the community nursing service, which enabled service managers to be alerted to staffing issues on a daily basis. Senior managers told us that staff were asked to report staffing incidents when they felt staffing levels were impacting on patient care.

- Staff at the podiatry service told us service leads received patient safety alerts from the central alerting system (CAS). The leads would then cascade any relevant alerts to their staff via email. Service leads had to respond to the quality governance officer outlining any actions they had taken in response to the alerts.

Community nursing

- In the 12 months prior to Nov 2015, 50% of the incidents reported, concerned pressure ulcers.Data on pressure ulcers between April and September 2015 showed that almost 10,000 patients were seen in district nursing and 88 grade 3-4 pressure ulcers were reported. 20 were reported as 'avoidable', 25 as unavoidable and 43 awaiting classification.
- A service manager reported an average of 15 to 20 incidents were reported each month across each borough. They included tissue viability, medication, safeguarding and serious incidents (SIs). The electronic reporting system was discussed with two permanent nursing staff who had only reported four incidents between them over the past 12 months.
- Trust quality priorities for 2015/16 included 'skin care - ensure patients at risk of pressure damage receive best practice care. 4 supporting metrics in place including reducing % of avoidable HRCH acquired grade 3 & 4 pressure ulcers to 0%'. In April 2015, the trust implemented a multi-disciplinary approach to pressure ulcer prevention.
- Pressure ulcer incidents were escalated to the pressure ulcer lead and tissue viability team if teams felt this was required. They were kept open while an investigation was ongoing.
- The community nursing risk register highlighted that over 100 incidents reported through the electronic reporting system, were awaiting manager's review, with the highlighted impact including delayed learning.Senior managers told us that with regard to the high number of open incidents, that for a while there had only been two service managers in post instead of four, which had meant a shortage of personnel to carry out investigations. To rectify this it was intended for the newly recruited practice development team to work through the open incidents with team leaders to review and close. A training need had been identified for teams to learn to do root cause analyses. Five training sessions were scheduled to take place by September 2016. It was estimated that 50/60% of staff would be trained by September. Band 6 and 7 nurses and matrons were required to undertake the training.
- Each team held monthly meetings where incidents were discussed and included lessons learned and actions. We were told that clinical governance kept a record of incidents and RCA will be put on to the electronic reporting system.
- Nursing teams held reflective learning panels, which was a face to face meeting and separate to the usual team meetings. Once investigations were complete they were discussed learn from the process and the result. Staff told us they were involved in learn and share monthly meetings which sometimes did not occur due to demand and capacity pressure on the service. Managers and practice development leads were now supporting them which had improved delays in dealing with incidents. Reflective learning panels were attended by district nursing team leaders and district nurses as well as safeguarding leads, tissue viability and clinical governance leads. Minutes showed meaningful discussion about avoidable pressure ulcer and concluded with learning for action such as 'inconsistent documentation and prompt upgrade of equipment and identification of patient's deteriorating health'.
- However, band 5 nurses we spoke with told us that feedback from the electronic reporting system was not always provided to them, and were not able to give examples of learning from incidents from other areas of the trust. Band 6 and 7 nurses were not able to provide examples either.
- The lead nurse for pressure care told us they would will meet at DN offices. If there was an incident the team leader will inform the patient verbally. If there was a RCA then the patient would be written to. Any verbal informing of patient was recorded through the electronic reporting system along with the outcome of any investigation. We saw evidence of uploaded reports

and actions that action had been taken. The service lead told us that letters went to patients with any findings on investigations along with any follow up if needed and this was sent by clinical governance.

Duty of Candour

- Senior managers told us that the Duty of Candour started with the team leaders, where the expectation was for them to carry this forward and disseminate this culture through the team. We were told that this made teams feel vulnerable and it was recognised that work was needed to assist staff in feeling more confident with Duty of Candour. A training session took place at the leadership forum. On the electronic reporting system there was a checklist to remind staff about duty of candour at stages of the incident reporting process.

Safeguarding

- Safeguarding adults information was displayed in the Richmond neurorehabilitation team's office. This included guidance for staff on contacting the local authority safeguarding team.
- We saw evidence that staff at the learning disability service were making appropriate adult safeguarding referrals. Staff we spoke with were aware of the trust adult safeguarding leads and knew how to contact them. The leads were described by staff as being helpful and supportive with safeguarding issues.
- Staff received training in adult safeguarding as part of their mandatory training. All community staff received safeguarding adults' level one training. Staff received training updates at a level appropriate to their area of work
- Staff we spoke with were able to describe the categories of abuse and how they would report potential safeguarding issues. Issues were reported to the safeguarding lead for further investigation. Learning from safeguarding investigations was shared at team meetings and across the service where appropriate.
- Staff at the RRRT team told us that social workers worked in the team and would advise on safeguarding issues.
- Patients we spoke with told us they felt safe and expressed confidence in the staff that worked with them.
- The community learning disability team's staff received a clinical support pack. This included information for staff on the trust's 'speaking up (whistleblowing)' policy. This gave staff information on how they could report concerns about risk, malpractice, or criminal activity by a member of staff. Staff could report concerns via the trust's intranet or by contacting the trust's speak up guardian, this was a member of staff who was independent of all the trust's internal structures and reported directly to the trust's chief executive officer. Staff could also report concerns to the Quality and Clinical Excellence team.

Community nursing

- Nursing staff and team leaders all reported that they felt supported by the trust's safeguarding leads, were able to name them and reported good working relationships.
- Regarding tissue viability and pressure ulcers, senior managers told us the culture was to report all pressure ulcers. It was recognised that the number of grade 2 community acquired pressure ulcers reported was rising and believed this was in part due to the raised focus on pressure ulcers and the work of the pressure ulcer prevention lead nurse.
- Monthly quality and safety meetings identified any trends within safeguarding. Falls were also reviewed. Minutes were provided which demonstrated this was a trust wide meeting with key personnel in attendance such as safeguarding leads and service directors.

Medicines

Community nursing

- A pharmacy inspector visited a DN team, accompanied them on home visits, spoke with staff and patients and looked at four medicines records. Medicines were observed to be prescribed, supplied, stored and administered appropriately.Controlled drugs were handled appropriately, with the involvement of other clinicians (e.g. GP) as necessary.
- We found that staff were appropriately trained in the administration of medicines, including for high risk procedures involving medicines such as the intravenous administration of antibiotics.We observed one patient who had a controlled drug pain relief patch removed

and a new one applied.The nurse demonstrated good practice with regards to the administration, record keeping and disposal of this medicine, in line with guidance and legal regulations.

- Some district nurses were independent prescribers. Although they didn't prescribe many medicines, they did receive support for this role via the medicines management team.Blank prescription pads were securely stored in locked cabinets and the serial numbers of prescribed medicines were recorded and sent to the medicines management team for audit.
- We reviewed medicines administration records for 5 patients held in patients' homes and community sites.These were completed accurately, with no omissions seen.Staff were aware of how to recognise and report medicines related incidents.They were able to demonstrate understanding of past mistakes and learning that had occurred as a result of this in order to prevent reoccurrence of this in the future.
- We observed nurses talk through the uses of different medications with patients and advised on self caring. We were told the service promoted this approach.

Environment and equipment

- Services were provided in well maintained premises. There was full disabled access with lifts, ramps and disabled toilet facilities all present. Signage in health centres and clinics was clear and directed patients to appropriate areas.
- Premises contained adequate waiting facilities with comfortable chairs and patients had access to drinks and other refreshments.
- The wheelchair service had a contracted external provider that repaired and maintained wheelchairs supplied by the trust. People were given telephone contact details for the external provider in order that they could contact them directly.
- Podiatry equipment records were identifiable and traceable with service dates recorded to ensure that they were maintained in line with manufacturers' recommendations. We noted that these dates for servicing were up to date.
- We found that the conditions of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 were being met. 'Sharps' waste was disposed of in appropriate receptacles which were properly labelled.

Community nursing

- We spoke with a band 5 nurse who gave examples of specialist beds provided to patients in their homes. This was following MDT involvement and a temporary inpatient stay to stabilise care.
- On a DN home visit we observed a BP machine being used. We were told it had been calibrated by the trust's medical physics department but the trust told us it had been calibrated through an annual contract. There was a standard checklist of DN equipment including a Doppler machine and sharps boxes. Each diabetic patient had a glucometer. Nurses had their own glucometers with quality control solutions to check their accuracy. Specialist nurses ran education courses for staff on different sites.
- All equipment was maintained under contract with a local acute trust. Equipment was supplied by NHS Supplies and ordered centrally if more was required which must be signed off by a service manager.
- All premises were maintained by the trust estates team.

Cleanliness, infection control and hygiene

- We saw that premises where patients were treated were clean and hygienic. We saw cleaning schedules that clearly set out how and when premises and equipment should be cleaned. Patients we spoke with did not raise any concerns in regards to the cleanliness of the CAS clinics or health centres.
- We observed that clinic environments and offices we visited had adequate supplies of personal protective equipment (PPE). We observed staff using PPE appropriately in clinics. We also observed staff carrying adequate supplies of PPE, and using PPE when they visited patients at home.
- We saw that RRRT staff had adequate supplies of personal protective equipment (PPE) and hand sanitizer when attending to people in their own homes. We observed a Band 7 nurse from the RRRT team employing appropriate hand hygiene during a home visit.

Requires improvement

Are services safe?

- We viewed the podiatry service's hand hygiene audit for 2015/16, we saw that the team had achieved 95% compliance with the audit in the previous year.

Community Nursing

- On home visits, we observed good practice with hand washing, personal protective equipment (PPE), non-touch techniques for dressings, packing and skin protections applied. For instance, a visit to a patient with a leg ulcer that required daily dressing. Another home visit to an elderly patient, a wound was dressed by nurse using clean technique and delivery of procedures using PPE; gloves and apron throughout the procedure. Elsewhere we observed good evidence of correct hand washing procedures and appropriate PPE by staff on visits.
- Practice development leads reported that staff were supported on infection control practice around screening of patients, essential audits on hand hygiene, cannulation and pre and post catheter care.
- No infection control issues in community nursing had been identified by the trust. Hand hygiene audits were at 98% compliance and there were no issues with regards to wound care. We were told there had been one case of Bacteraemia but this was investigated and found to not be trust acquired.

Mandatory training

- Staff we spoke with told us they were supported to attend their mandatory training by their managers and that they received reminders when it was due.
- We viewed the community learning disability team's mandatory training record and saw that staff mandatory training was up to date.
- Staff across therapy services reported problem with the 'Wired' electronic record not updating staff training records when training had been completed.

Community nursing

- There were online mandatory training packages for staff. Time was built into work time, reminders were sent to those who had not undertaken their mandatory training. It was recognised that improvement was required. They felt they had good training on safeguarding but not so good on information governance. The aim was to give each nurse a full day to complete their mandatory training, which would be built into the rota. Nurses told us there was a training record system called 'WIRED' which had not been working for some time. Staff were feeling frustrated because attendance records held on the system were incorrect. The system was showing red for many staff when many felt this was not a true attendance reflection.
- Staff told us they were booked on to upcoming course if they were due and it was individual staff responsibility to complete this. Nurses whose mandatory training was showing as red had automatically been booked on to training, but because the system was incorrect staff were finding themselves booked on training already attended.
- Staff told us the principle was that patient care was prioritised over training. Short staffing impacted on training attendance so sometimes it was left not done. The monthly divisional report for community nursing for the year up to February 2016 showed mandatory training figures RAG rated against trust targets. Out of 17 separate community nursing teams, including specialist teams, only five had met trust target for training. This however, showed an improvement on previous months' performance.

Assessing and responding to patient risk

- The RRRT team used the national early warning score (NEWS) tool observation charts. This involved staff in undertaking physiological observations that were fundamental to ensuring that people were safe and that healthcare professionals were are aware of people's health status.
- The risk of patients falling was identified as a primary concern for the neuro rehabilitation team. Staff told us they could refer suitable people to the falls service who offered two classes a week. However, staff said they always discussed people's condition with the Falls service prior to referral, as not all patients with neurological conditions were suitable for he service.
- Referrals from G.P's and hospitals to the RRRT team were immediately logged onto SystmOne, which identified patients who were at risk of deteriorating.

Community nursing

Requires improvement

Are services safe?

- Risk assessments were in place in patient records we reviewed. Staff were responding to patient risk. Nurses were aware of patient histories. For instance, on a home to an elderly patient, the DN was aware of the history of the condition and treatment, and treated the patient appropriately. Elsewhere we found the a tissue viability nurse (TVN) was involved in the patient's care where appropriate. Pressure areas were discussed and fluids were encouraged. A podiatry visit was planned for the following day for the patient, hospital o/p appointments were also planned as part of the package of care. Patient also saw their GP. We observed a DN discuss mobility needs with the patient and advise on getting in and out of bed safely. On a home visit to a patient with a leg ulcer that required daily dressing, a nurse identified the infection of the patient's leg two days ago, liaised with the GP where antibiotics were prescribed. The DN stated the patient's leg appeared improved today.
- There were risk assessment tools in the assessment packs including MUST and Waterlow scores. The new practice development team were planning to move forward with updating risk assessment processes. It was also reported that assessment screening that took place included screening for dementia, SSKIN, Waterlow (MUST), depression, falls, pain and infection.
- In the Hounslow integrated community response service patients were risk managed before referral to other community teams for longer term care such as GP, DN, end of life and longer term rehab. If hospital referral/ admission was required this was via A&E or the team's medical registrar.
- Nursing staff told us bed rails would not be issued unless a patient had family/carer support 24/7. Nursing teams had refused bed rails on this basis due to risk, for discharged patients when the hospital had completed the bedrail assessment. Other staff told us there was not a bed rail risk assessment currently in use and they were not sure why. Staff currently used the disclaimer form and hospital assessment notes regarding using bed rails.
- If nurses visited patients alone there was a ring in and ring out system in place.

Quality of Records

- The community adults service integrated working agenda meant that staff had been trained in the NHS SystmOne, a clinical computer system used by healthcare professionals in primary care. and the local authority's Framework-i electronic records system. This meant NHS staff could have access to information on people's social care needs without the delays caused by having to request information directly from the local authority. This meant staff in the RRRT team worked across two computer screens in the office as the systems could not copy information across systems. Staff told us it also meant that some patient information needed to be entered on both systems.
- Staff at the RRRT team told us GP's used a different records system from SystmOne. This caused problems for staff in accessing people's information in a timely way, as Richmond GP's were unable to record directly onto SystmOne.

Community Nursing

- DN documentation was kept in patients' homes and records were currently written on laptops, offline, and then synchronised with trust drives when back at base. A service manager told us the service was moving towards mobile documentation and they were also awaiting investment by the trust for computer tablets.
- The Hounslow integrated community response service had 4g laptops since January and worked as a paperless records team. Progress notes or documentation were not left in the patient home. Instead, a leaflet was left with the patient about the service, which made it for teams working alongside to understand the team's involvement with the patient. 'Actions and outcomes' templates on System One were used. Any data on System One was shared with GPs as long as patients gave their consent.
- We observed well kept notes that reflected the care and treatment. There were regular updates given, care plans had been updated, notes were clear, signed and dated. Where used, System One was also completed. For instance, on a home visit to a patient with a leg ulcer that required daily dressing, notes were found to be clear and up to date, signed and dated along with a clear care plan. On another home visit to an insulin dependant diabetic, a wound assessment chart had been completed and comprehensive initial assessment in notes, MUST and waterlow. Wound assessment charts were seen in homes and reassessment at each unit,

measurements showed wound healing. All details were then put on system one or data bases at the end of shift back in base. Once a patient was discharged, notes were brought back to the office and archived for 6 months.

Staffing levels and caseload

- The community learning disability service had three staff vacancies. A Band 7 clinical psychologist post was being advertised. Staff told us the impact of the vacancy had been minimised due to the band 8A lead psychologist from the autism service providing clinical supervision for the team's Band 7 clinical psychologist. A Band 6 nurse post had been recruited to and a new Band 6 nurse was due to take up their post in April 2016. The team also had a Band 5 that had been recruited to, and the nurse was waiting to start a preceptorship programme with the team.
- Podiatry staff at Hounslow told us they were unable to attend some professional development events, for example, 'road shows' due to clinical commitments. Podiatry staff told us team meetings and in service training were "on hold" due increased clinical work.
- The RRRT team told us they had very few vacancies. The manager told us there were two WTE Band 6 vacancies in the team, but these had been recruited to and the new staff were undergoing their pre-employment checks. The team had one OT vacancy that was being provided by the local authority. The team also had 0.5 WTE physiotherapist vacancy with interviews for the post being arranged. The team also had a 0.5 WTE social work assistant team manage post that was being advertised. The team manager told us the team had made advances in the past 18 months in the recruitment and retention of staff, moving from a position of using 75% agency staff to almost fully staffed.
- The neuro rehabilitation team were fully staffed. Staff told us the permanent manager was on secondment until the end of May 2016, and the assistant manager was covering the manager's post. A Band 6 locum had been employed to maintain staffing levels.
- The RRRT team had a GP on a seven day rota, supplied by an external provider.
- Locality leads and operational managers assessed the level and acuity of caseloads, and allocated staff resources to meet the needs of all teams.
- Staff at the podiatry service told us they were seeing 12 new cases a week, which had resulted in the team being unable to complete some quality assurance tasks.
- The neuro rehab team had a 1.0 WTE multiple sclerosis nurse who was funded by an external company. The funding was due to end in March and the team were putting a business case together to have the position funded. The post is now funded by the CCG.

Community nursing

- There was a high vacancy rate within the DN service. At present it was running at an overall rate of 22% and a 30% vacancy rate for band 5 nurses. DN vacancy rates as at 5 February 2016 were reported as between 11 and 39% for different DN teams.Over the three month period between July and September 2015, the volumes of shifts not filled by bank or agency staff ranged between 115 and 23.
- Empty shifts were filled using bank and agency staff. The trust continually worked with three agencies for consistency but had other agencies available to use if needed and regularly booked agency staff for three month blocks. Bank staff were aligned to the individual teams and were often retired nurses who returned to their old teams, working two to three days per week.
- The community nursing risk register highlighted difficulty in recruiting to community matron roles which was identified as likely to impact on care of patients with 'long term conditions'. Keeping well practitioners had been recruited to counter this risk. Senior managers reported that nurses were recruited to these roles at band 6 and used as a way to 'grow our own' matrons. The trust advertised vacancies on the NHS Jobs website and at community nursing job fares as well as local university year 3 nursing students. Trust student nurses were encouraged to work as band 5 nurses and a preceptorship programme was being developed to assist with this. The trust also hoped to incentivise band 5 nurses to develop at the trust but we were told they tended to move on very quickly. So far eight had been promoted to Band 6. There were four band 6 nurses due to complete the district nursing course by the end of August 2016.

Requires improvement

Are services safe?

- The divisional manager for community nursing demonstrated the safe staffing tool to us. It projected the shifts that would be required for each team based on acuity. Agency staff were not sought until at least two or three shifts were not covered per team. Up to this number the team were expected to manage the empty shifts themselves. Team leaders co-ordinated the shifts and had over all responsibility for day to day management. Vacant shifts were reported up to service managers.
- Missed appointments were not recorded within the tool at present. We were told this was due to begin in May 2016 and that System One would also be used in the future to more accurately predict the number of staff needed for each shift.
- The safe staffing tool did not record shifts that not been filled. We could not see how they could assure us that they know how many shifts went uncovered, how many appointments were missed and if targets were met. They felt that the DN were able to flex to meet demand and worked their caseloads to meet needs.
- District nurses told us that the high vacancy rate impacted on patient care. For instance, through the skill mix as agency nurses could not perform tasks such as syringe drivers, IV therapy, compression bandaging, Doppler and venepuncture. This put more pressure on permanent staff including band 7 which meant that leadership also suffered due to lack of time as band 7s were doing band 5 nursing work. Nurses also told us that the high vacancy rates impacted on the number of shifts they worked at weekends and permanent staff had less flexibility, have to work more bank holidays and weekends because they had the skill sets needed, they covered weekends as bank and agency were not always equipped to do so.This impacted on staff family life and also workload during the week, Monday to Friday, when staff have days off due to working weekends.
- A bank nurse told us they had worked four days in the last two weeks and that around 20 shifts were regularly covered in their team by agency each week. Holiday periods were difficult such as recently when agency nurses cancelled or call in sick. There had been four cancellations in the recent half term week which was viewed on the off duty rota.
- An agency nurse told us they were block booked for 37.5 hours most weeks and were included in hand over and the clinical supervision group. They said they felt part of the team and well supported by the team. They told us they had the skills from their previous job prior to retirement including catheter male and female and suprapubic catheter care. They were not able to give IV therapy, syringe drivers for end of life care, venepuncture for bloods, leg ulcer assessments or compression bandaging.
- Workload and lack of time impacted on the service in other ways too. In one DN team we found the team leader had over 140 visits with no outcome on the electronic record keeping on SystmOne. Their reason for this was workload and lack of time at the end of the day. A service manager reported an average of 15 to 20 incidents were reported each month across each borough. This included tissue viability, medication, safeguarding and serious incidents (SIs). Incident reporting was discussed with two permanent nursing staff who had only reported four incidents between them over the past 12 months. An allied health professional told us they spent time reporting 'other people's incidents', meaning that others did not report them.
- The Community Nursing Service Action Plan identified 18 actions that monitored progress on key areas of performance. They included nurse recruitment, staff turnover and agency spend. Progress was regularly monitored and updated. The most recent plan reported: Nurse recruitment as: 'Although the rolling recruitment programme has been successful, there are still a number of vacancies to be filled in notably at B5 level (39% vacancy rate compared to overall service rate of 24%) despite good staff retention.' Turnover rate against a trust target of 17%, was currently stated as: 'turnover rate for the service remains high at 22%'. Agency spend was not to exceed 12% of the current pay spend. Progress was currently stated as:'Actual agency spend approx. 13% of pay spend across the service. Practice development nurse providing dedicated support to teams to undertake further caseload review and scheduling as current workload indicates higher staffing level requirements'.

Requires improvement

Are services safe?

Managing anticipated risks

- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather. Staff told us that SystmOne identified vulnerable patients and calls would be allocated on the basis of care and complexity, this ensured the needs of vulnerable and highly dependent patients were met during the winter and during heatwaves.
- The service had a winter plan in place. This included community staff having access to 4x4 cars to maintain staff safety and to support access to patients in all community settings; the plan also provided telephone access to specialist services, which would provide advice to patients and staff during adverse weather.
- The RRRT team had a GP attached to the team as part of the winter pressures planning. This was part of the Richmond GPs CQUIN initiative.

Community nursing

- Senior managers reported that there were no anticipated risks in terms of their being any seasonal fluctuation in demand and that the referrals into the service were constant.

Major incident awareness and training (only include at core service level if variation or specific concerns)

- A DN service manager was undertaking the 'incident on call' training shorty and there were business continuity plans in place for all teams within the trust. The manager on call will be the Silver Command. The trust had undertaken a table top practice, where the scenario was a hospital fire which involved the ambulance and police services. This exercise was undertaken one month prior to the inspection.

Good

Are services effective?

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

Summary

The trust had recently recruited two practice development leads who had made firm plans and some progress on equipping the nursing service with the right skills to carry out their roles competently. We found many examples in practice of evidence based care and treatment during observations of home visits and the trust had a system that enabled teams to be up to date with good practice guidance. Improvement had been made on rates of clinical supervision within community nursing, which included agency and bank staff.

Staff at the RRRT had developed the role of the 'Trusted Assessor' which meant that all qualified staff were trained in using the national early warning score (NEWS) observation tool. The team recorded that a patient was open to them on SystmOne but would not write in patients' progress notes. This could pose problems as both the district nurses and the RRRT team worked with the same patients and it could be difficult for staff to communicate with each other or know of each other's involvement.

Evidence based care and treatment

- We viewed a selection of policies and procedures at the community learning disability service. Staff explained these had been developed to reflect relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), government departments and professional bodies. Staff at the service understood their individual roles and responsibilities in the delivery of evidence based care. Patient's assessments were completed using templates that followed national guidelines. For example, the service's assessment was based upon the Care Act 2014 national minimum eligibility criteria, this is a minimum threshold to assess people's eligibility to support services.
- Staff we spoke with understood how NICE guidance informed local guidelines. We observed staff following appropriate assessment guidelines when delivering care to patients. We saw copies of relevant documents were available at bases for staff to reference, and staff told us they could also access this via the trust's intranet site.
- Staff at the Hounslow podiatry service told us they received emails from the trust's audit department when there were new guidelines that involved changes to practice which might affect their area of work.
- Clinical procedures undertaken by the neuro rehabilitation team were based on best available evidence. For example, the national service framework for long term neurological conditions.
- Staff at the learning disability service could access guidance and pathways on the trust intranet. For example, we viewed the learning disability service's dysphagia care pathway for speech and language therapy (SALT).
- The RRRT team had an assistant team manager who acted as lead for NICE guidance, this included ensuring that staff were aware of any new guidance issued that was relevant to the team. Staff told us NICE guidance was discussed at team meetings.

Community nursing

- Practice development leads reported that good practice guidance including new RCN and Nice guidance was disseminated by the trust to practice development leads who reviewed their practice on the back of these alerts.
- There were risk assessment tools in the assessment packs including MUST and Waterlow scores. The new practice development team were planning to move forward with updating risk assessment processes. It was also reported that assessment screening that took place included screening for dementia, SSKIN, Waterlow (MUST), depression, falls, pain and infection.
- The CQUIN project manager told us about a number of CQUINS in place within the trust's two boroughs which were also demonstrated through documentation. In Richmond they included catheter care that included a passport, A&E attendances and working with care homes and reducing hospital admissions for cellulitis. In Hounslow they were working with local acute hospitals

on catheter care and were on target to achieve a 15% reduction in catheter use by the end of the year. There was a personal care framework for providers and giving advice and training on pressure ulcer care

- We found many examples in practice of evidence based care and treatment during observations of home visits. For instance: An insulin dependent diabetic, having morning visits after surgery we found assessment charts completed including a comprehensive initial assessment in notes, MUST and Waterlow.
- Comprehensive wound assessment chart included size of wound, exudate, surrounding skin, wound bed, infection, pain and followed best practice (Royal Marsden Clinical Guidelines 2011).
- A wound assessment and review of healing of a carcinoma that had been removed from foot. The dressing used to soften and add moisture to wound bed. Wound measured and recorded to monitor healing. Wound care chart followed best practice. We found blood sugars of one patient within therapeutic range 6-12 mmol (one above in three weeks). Care plan for low blood sugar in place ie if below 5 mmol give breakfast and omit insulin and recheck after 20 minutes.
- Risk assessments SSKIN in place and reviewed 3 monthly. We observed a nurse checked pressure areas and educated patient about what to look out for such as non blanching skin, discomfort when sitting. Wound assessment assessed patients for healing.
- There was good infection control procedure, hand washing and use of gloves and apron, cleansing wound and non-touch placement of dressing. Advice was given on wound care, i.e. nurse to visit to check wound, contact nurse if any oozing from wound. We found the SSKIN care buddle being used; Waterlow, MUST, continence, pressure cushion, nutrition and hydration all assessed and the nurse was proficient in this.

Pain relief

- The podiatry service showed us a pain tool they used to assess a patients level of pain. Staff told us people were asked if they were experiencing any pain at every appointment and people who reported any pain would receive a pain assessment. We did not view any completed patient pain assessments. However, we viewed the podiatry pain assessment tools and staff explained how these would be used in practice.
- Staff at the RRRT team told us the team did not manage people's pain, but that if a person was in pain, advice was available from the person's GP, District Nurses and Community Matrons, Princess Alice Hospice, and the acute hospitals pain clinics. Staff told us they would always refer a person with pain to an appropriate service.
- On home visits with DNs we observed pain assessments and pain management. For instance, we observed a nurse seek permission from the patient to discuss the pain with their GP. We also observed pain assessments and checking in with carers about pain. Nutrition and hydration and mobility were discussed, blood pressure, oxygen saturation and respiration and temperature were also checked in relation to pain assessments.

Nutrition and hydration

- Where a need for additional support with nutrition and hydration was identified, for example with diabetic patients, community and specialist nursing staff referred patients to a dietitian, who provided practical advice for patients about healthy food choices and to work with patients to change their eating habits.
- We accompanied a RRRT dietitian on a home visit to an older person with dementia. The dietitian advised the person's carer on correct storage of food and asked an RRRT care assistant to provide food preparation advice to the family.

Community nursing

- During home visits with DNs, we observed that the Malnutrition Universal Screening Tool (MUST) being used. Patients were asked if they had any significant changes in weight since the last visit and if they were eating well or had any problems with keeping food down.
- We observed that home visits advised on fluids and importance of taking on board water as well as checking on bowel movement Wound charts were used and completed.

Good

Are services effective?

Competent staff

- We saw records that showed 100% of staff had attended a corporate induction programme.
- We were shown records by the RRRT team that showed competencies relevant to staff roles had been developed and there were systems to ensure competency was demonstrated and reviewed. For example, the team had developed the role of the 'Trusted Assessor'. This meant all qualified staff including nurses and therapists were trained in using the national early warning score (NEWS) observation tool.
- We viewed the neuro rehab team staff training spreadsheet. We saw that staff mandatory training was up to date. Staff told us there was a problem with the Trust's electronic training record, as staff had completed e-learning and their training records had not been updated to reflect this.
- Staff at the neuro rehab team received regular competence assessments, as well as competence assessments in regards to using the team's equipment.
- A corporate induction was completed by staff joining the service. Staff told us new staff also received an induction at locality level.
- Staff training and development was supported at the neuro rehab team and the learning disabilities team. We found services encouraged skills development. Staff of different grades confirmed that training needs were identified as part of appraisal, and staff could request further training that was relevant to their role.
- We viewed the community learning disability team's preceptorship programme, this was based on the Edward Jenner programme, this was a patient focused approach to health care staff development.
- Staff at the RRRT team told us 'Trusted Assessors' were staff who were trained in the use of NEWS. The training included three observations of practice and monthly updates. Trusted Assessors were also trained in using the pressure ulcer prevention SSKIN bundle.
- The Richmond neuro rehabilitation team had a specialist Parkinson's nurse, this was a nurse who had undergone extra training to specialise in Parkinson's disease.

Community nursing

- The trust had recently identified the need to provide support to community nursing staff at the front line and had created two practice development lead nurse posts. They identified practice needs and where additional support was needed. They provided practice support, education and training. They worked alongside the practitioners on the front line and with newly qualified nurses on the preceptorship programme, which was still in development.
- Practice development leads had completed a competency audit for all nursing staff. Nurses were asked to identify which key skills they had and what needed updating. The list of key skills included catheter care, use of syringe drivers, intravenous drugs, continuing assessment, nurse prescribing, cannulation, venepuncture, central line care, VAC, zoladec dopler and ear syringe. Practice development nurses had also visited patients with nurses to identify other competency needs such as diabetes care and SSKIN training. Practice development were in the process of identifying and developing what support and training could be provided in-house at the time of the inspection.
- Practice development leads reported that staff had access to a local university for ongoing training, e-learning through Skills for Health and Health Education England and that all staff could access Clinical Skills.net. Practice development leads reported that there were five nurses who had been identified to do their DN training in 2016/17.
- Practice development leads told us they attended the inductions for new staff so that they had established support links and contact details for future support around practice issues. Bank staff had a corporate induction, a local induction and also accessed mandatory training. Agency staff were on the LPP framework and undertook a quick site based induction. There was also a basic two sheet checklist for agency staff who were only coming to work for the trust for one day. Training was arranged for agency staff that had been with the trust for some time. The majority of agency staff were booked for three month blocks and as such they were part of the team and included within the clinical supervision structure. Bank staff were included in the staff skills audit.

Good

Are services effective?

- A new starter band 5 nurse told us they had two weeks as supernumerary and shadowed the band 7 and other nursing staff. They were supervised by the band 7 for practical work and had completed a mandatory training package including CPR, manual handling through an online training portal. A new in post band 5 nurse told us they felt supported by a band 7 nurse and that a training package/induction was in place and included BLS, MH, fire, aggression and violence, lone working, infection control and safeguarding. Also put on courses for wound management and leg ulcer care, each of two days length.
- A service manager reported that group clinical supervision took place eight times a year with an average attendance rate of 60 to 70%. We were told that annual leave, training and sickness can impact on this. We were told it was mandatory for staff to attend 75% of these and the service lead told they felt their staff were compliant with this. Band 5 nurses told us they took part in group supervision. Clinical supervision groups were organised to take place every six weeks within nursing teams. Practice development told us there was an 80% uptake required from all nurses. We were told an audit of clinical supervision took place in January 2016 and was in the process of being reported on by the trust audit team. A policy and structure process for clinical supervision and audit was requested from the trust.
- The Community Nursing Service Action Plan identified 18 actions that monitored progress on key areas of performance that included clinical supervision. Progress was regularly monitored and updated. Current progress on clinical supervision was reported as aiming to achieve a clinical supervision target of 85% by 31/3/16 and current quarterly trajectory of 60%. Progress was currently stated as: 'Quarter to date position is 83% amber against 60% requirement, with monthly position red 82.8% against 79% requirement from February board scorecard data. Local service data collection has position at 87% as at 12th February.'
- Appraisal rates by DN teams varied from 100% in the Hounslow and Sheen and Barnes teams, to 50 and 58% in Chiswick and Great Western Road respectively.

Multi-disciplinary working and coordinated care pathways

- The community learning disability service had a holistic approach to assessing, planning and delivering care and treatment to people who used services. This involved five social work locality teams based around GP clusters. Staff told us the service worked closely with social workers, with whom they shared an office, on joint agendas.
- Staff at the RRRT team told us multi-disciplinary working had resulted in staff sharing knowledge within the team.
- We found that social care staff were employed by the trust and co-located with health professionals which facilitated a joint approach to providing holistic care that met the needs of patients and their families and carers. We observed interactions between these staff groups at the RRT team which enabled them to respond quickly to the needs of patients, especially when these were changing. We saw that social care assessments were offered by the trust's social workers.
- Specialist clinical leads worked effectively in multi-disciplinary teams. For example, the clinical lead for the specialist podiatry service maintained links with other specialists including physiotherapists and occupational therapists.
- The RRRT team attended multi-disciplinary meetings daily at Kingston hospital, and worked closely with staff at West Middlesex hospital on hospital discharge planning.
- Staff at the RRRT team told us they had very good relationships with stakeholders. Staff told us stakeholders often attended team meetings and shared knowledge with the team. For example, staff told us Age UK had recently provided learning at a RRRT team meeting.

Community nursing

- We found numerous examples of multidisciplinary working which cut across many aspects of care and support.
- The DN teams were aligned to GP surgeries for closer working and held monthly meetings with GPs who they felt were accessible to discuss patients' needs and care. Some of the DN teams shared team bases with social

services, OTs and physios and was open plan. It was reported that with social services on site made safeguarding much easier and quicker, for example if pressure ulcer grade three or four and concern over care agency work together to solve problems.

- Diabetic and tissue viability nurses offered specialist support with complex patients.
- The Hounslow integrated community response service was a multidisciplinary team consisting of OTs, physios, a GP, social worker, handyman, nurses and HSCW. There were seven nurses, four OTs, five physios. All disciplines had staff from bands 5 to 7. Patients were assessed by the multidisciplinary team for appropriate longer term care such as GP, DN, end of life and longer term rehabilitation. The pathways open to the service had been streamlined over the last 18 months so referrals were easier and more aligned to other community services.

Referral, transfer, discharge and transition

- Referrals for the wheelchair service was reviewed by a clinician and prioritised based on the health risk to the person being referred. Urgent referrals were seen within five working days and standard referrals were seen within 20 working days. Once a referral had been screened the person being referred was contacted via telephone or post to arrange an appointment.
- Referrals for in hours community nursing in Richmond were made via the Single Point of Access (SPA), 7am to 7pm, seven days a week. The SPA team worked to SOP's to ensure patients were referred to the appropriate services, in the correct timescale. The call centre provided a single telephone number for referrals to community services and a single information point for social care. This had the aim of making it easier for people to know where to call in order to get the right help and information they need. Services responded quickly and waiting times were low in the service areas we visited. Referrals in hours went directly to the team, who triaged and referred people on to the most appropriate service.
- The Richmond Response and Rehabilitation Team (RRRT) facilitated hospital discharges and provided same day care or therapy support to patients who had been discharged. Access to the service was via the SPA.. Urgent referrals for immediate response were allocated through an MDT process to determine the level of action required and the appropriate management of risk. The service provided a seven days a week daily duty system with guaranteed same day response from both care and therapies. Care plans could be negotiated at weekends to support weekend hospital discharges.
- RRRT was a service set up to avoid admissions where possible by triaging patients in the community to avoid them being admitted to hospital, or working with patients who had been admitted to hospital on their discharge home.
- The RRRT had an urgent two hour response time for patients on the caseload. Staff told us that if an urgent task was received, the team taking the referral would contact the patient to establish the nature and urgency of the call and to provide interim advice. Non-urgent calls would be offered an appointment for a visit from a care coordinator on a specific day based on treatment required.
- Community adults services had referral pathways and procedures in place. Referrals to community services were from a variety of services including GP's, practice nurses, district nurses, patients being discharged from hospital, complex cases in nursing and residential care homes, and others including the police. Staff at the RRRT told us there were clear criteria for referral of patients which meant that inappropriate referrals could be identified.
- The RRRT team facilitated hospital discharges, reduced long-term care and provided out of hours nursing services. Therapists in the team provided goal-orientated, time limited interventions, aimed at improving patients functioning and independence. Nurses in the team could arrange domiciliary services to prevent avoidable admissions to hospital; and could ensure access to community nurses 24 hours a day.
- We viewed a range of care pathways at the community learning disability team, including the 'community nursing visiting depot clinic (intramuscular injection) pathway; the physiotherapy care pathway for people with learning disabilities; and the clinical psychology care pathway for assessment of a learning disability. These outlined the patients' journey through the

services, as well as the criteria for accessing the service, and any exclusion criteria. All the care pathways we viewed had flowcharts that mapped the patients' journey through the service.

- The RRRT team told us they could not commission new care packages at the weekend. However, there was an in-house team of eight rehabilitation assistants who could provide cover for new care packages at weekends. Staff told us new providers were tendering to provide weekend care and this was work in progress.

Community nursing

- On observation of home visits, we saw evidence of referral, transfer, discharge and transition with adult and end of life patients who required timely discharge from inpatient areas to the community and between community and specialist teams such as tissue viability and diabetes service.
- The trust used the Single Point of Access referral system for referrals and discharge from acute settings, who referred on to the teams. Needs were identified by a clinician at the Single Point of Access. The service were looking to add a band 7 nurse to Single Point of Access to improve the process of access to appropriate services.

Access to information

- Staff at the RRRT service and district nurses demonstrated how they could access information. For example, we viewed patient's paper based notes in their homes and saw these included care plans and risk assessments. RRRT staff also demonstrated the use of SystmOne to gain access to case notes and patients test results.
- Staff at the RRRT team demonstrated how they had access to both the local authority electronic records system and SystmOne. Staff explained that the RRRT team had access to both systems made it easier for staff to access relevant information from referral, discharge, transfer and transition in line with relevant protocols. However, the local GP's used a different electronic system, Vision 360. Staff told us using three systems meant accessing people's information could be convoluted.
- The RRRT team had access to the local authority electronic recording system. Staff told us this had increased their ability to deliver effective care and treatment by improving access to patient records whilst working in the community. However, staff had to use two computer screens to access each system. Staff told us there had not been any serious incidents as a result of using two systems.
- Staff at the RRRT told us SystmOne would record that a person was open to the team; but would not hold any clinical notes. Staff said DNs would telephone the team for information. However, this could be difficult as both the DNs and members of the RRRT team worked in the community, and it could be difficult for staff to communicate with each other. Staff also told us there had been incidents where RRRT staff had turned up at a people's homes when people had hip replacements and needed clip removals, and found that the DNs had arrived at the same time.
- The RRRT team's GPs did not have access to the Richmond GP's electronic record. Staff told us they would telephone a person's GP for information. Staff told us they always sought people's consent before accessing information from their GP.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of their responsibilities in relation to the Mental Capacity Act 2005 and could describe how they applied it in their daily work.
- We saw examples at the learning disability service of records of best interest meetings that had been held when patients lacked capacity to make a decision for themselves. Overall, the service complied with the Mental Capacity Act 2005, Code of Practice 2007.
- We found there were procedures in place for patients at the learning disability service who lacked capacity to have access to an Independent Mental Capacity Advocate (IMCA) when serious decisions about their health and welfare needed to be made in their best interests. We did not see evidence of the referral rates or patterns of community adults services overall performance in regards to IMCA referrals.

Good

Are services effective?

- Across community therapies we found patient consent forms had been signed by the patient or their relative and representative. We also observed staff from the RRRT team gaining verbal consent before providing care.
- We attended seven home visits with the RRRT and community learning disability team and observed staff asking patients for their consent prior to providing care or treatment.

Community nursing

- Consent was always sought as a matter of routine for care to take place and nurses always involved patients in decision making about their care.Verbal consent to treatment was obtained. Consent was clearly written in notes and permission to share information on system one. However, we found a lack of understanding about issues of capacity and consent among nursing teams. For instance, nursing staff told us they did not carry out assessments of capacity. DN team leaders reported they would do best interest assessments, but no formal process or training was in place. Nurses were unaware of any direct support links regarding dementia care. DNs we spoke with were unable to identify patients on their caseload with a diagnosis of dementia.

Good

Are services caring?

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

Summary

Patients and carers we spoke with were positive about the care and treatment they received. During home visits we observed staff responding to people in a kind and compassionate manner. People we spoke with told us staff always gained their consent prior to providing care or treatment.

We found many examples of respectful and compassionate care. We observed nursing staff explain procedures to patients and gain verbal consent to carry out procedures. Nurses were respectful and friendly to patients, offering emotional support in all of their interactions we observed.

Compassionate care

- Patients and carers we spoke with were positive about the care and treatment they received from Community Adult Services. For example, a person told us, "They are always there, which is very important."

Community nursing

- We found many examples of respectful and compassionate care. Nursing staff were polite and kind and explained procedure to patients. For instance, we observed a home visit with a diabetic patient where staff were friendly and approachable, sought permission to come in and give treatment. The patient's partner was happy with service from the nursing team who gave advice and supported her with insulin injections as she was needle phobic.
- We observed good interpersonal skills from DNs, good humour and respect. Dignity maintained at all times. We observed some exceptional caring. For instance, a patient had soiled themselves and were embarrassed. Nurses dealt with the situation maintaining the patient's dignity.
- A patient and wife made a point of telling us that the staff were always pleasant, washed their hands, wore gloves and aprons, and read the notes before attending to the patient. They felt that they had been well supported after a very anxious period in hospital.
- On a home visit to a patient with a leg ulcer that required daily dressing, the patient's dignity was observed during all interaction and treatment.

Understanding and involvement of patients and those close to them

- There was a large amount of printed information available to patients across the community adult services we visited. Patients could also access to information leaflets on the trust's website.
- People accessing neuro rehabilitation team services were given a therapy treatment and self-management folder. This gave people information on understanding their medical record, therapy advice as well as support networks people could access in the community.
- In our discussions with staff, patients and carers we found that there was an appropriate rehabilitation focus and that patients were encouraged to be partners in their care planning and enabled to participate in care activities.
- The community learning disability team had tablet computers with an easy read annual survey format. The computers also had easy read satisfaction questionnaires which were based on the NHS friends and family test. This was compiled into a patient liaison service divisional report, which was feedback to staff at team meetings.
- The community learning disability team's internet page carried information on advocacy services and local support groups.
- People we spoke with told us staff always gained their consent prior to providing care or treatment.

Community nursing

- We observed nursing staff were polite and kind and explained procedure to patients and gained verbal consent to carry out procedures. On a home visit to a complex discharge, we observed the nurse as polite and requesting admission and permission to sit. They listened attentively to the patient's history and needs and gained their consent to treatment i.e. clip removal.

Good

Are services caring?

- One patient told us they were very happy with the DN service. They told us nurses arrived on time, were polite and friendly and always explained everything. We observed the nurse was careful not to take over and were told the patient was independent prior to surgery and was working towards this again.
- On another home visit staff gave good explanations to the patient of healing of wound and progress. The patient's wife told us they felt the care given by the DN service was excellent and felt fully informed of the plans of care and not afraid to speak to the team members if there were any concerns or queries.
- On a home visit we spoke with a family member who only had praise for the DN staff. The family were aware of the plan of care and the times of the twice weekly visits. They were aware of how to contact the DN services if they needed to but said DNs always contacted them by phone to update them of visiting times.
- We accompanied a DN on a home visit to a patient living in warden accommodation with an abscess requiring frequent dressing changes. During the dressing change the DN continually spoke with the patient, explaining what they were doing and why. They also explained future planned visits. The opportunity to ask questions was given and the patient was happy with this plan of care.
- We observed a patient who was self administering an anticoagulant, praised by staff for managing this and being so independent. The course was monitored by DN and baseline observations were taken with patient consent. The patient told us they felt involved with their care.
- We observed patients and relatives who telephoned into the service greeted kindly and spoken with politely and patiently by the administrative staff. They were given advice as to visit times. Staff also called the relevant nurse for advice about visit times and then called the patient back.
- On a home visit with a TVN, the family were involved in the care and a clear description of care given and planned was given to the son and daughter.
- On a home visit to a patient with a leg ulcer that required daily dressing, there was good, clear communication between the patient and nurse. The patient told us they felt involved in their care and felt they were listened to by the nurses that visited.

Emotional support

- We observed staff providing emotional support to patients and to relatives. Staff were aware of the emotional aspects of care for patients and provided specialist support for patients where this was needed. A person who used services told us, "I have never felt patronised of talked down to by them."
- During home visits we observed staff responding to people in a kind and compassionate manner. All the patients and carers we spoke with were positive about the emotional support the community staff provided.
- Staff and patients told us about the emotional support staff had provided for patients and carers. For example, we saw a dietitian providing kind and considerate care and advice to a person and their family on food storage and preparation.
- The neuro rehabilitation team offered specialist multiple sclerosis (MS) services that offered fatigue management service to assist people with 'low mood'.

Community nursing

- Nurses were respectful and professional and friendly to patients, offering emotional support in all of their interactions we observed. We also witnessed them injecting some humour in to the visit that was appreciated by patients.
- During a DN visit for a change of dressing. The patient was given due consideration when DN arrived as they were having breakfast. They were given time to eat and when care commenced the patient felt well supported and given the option regarding whether it should take place in the lounge or the bedroom.
- We observed a home visit with a TVN who was supporting a DN and student nurse with a newly discharged patient who had recently had surgery, with a wound requiring Vacuumed Assisted Closure (VAC,

Good

Are services caring?

dressing to help promote wound healing). Dignity and privacy was observed in interactions and treatment of patient by the nurses, who described and informed of care throughout the visit.

Requires improvement

Are services responsive to people's needs?

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

Summary

The trust was meeting emergency and urgent community nursing referral targets but consistently breaching routine targets. The number of predicted contacts for community nursing services had been increased for 2015/16 but had already been exceeded with two months left to the year end. A system to assess demand and capacity categorised patient visits depending on complexity. Missed appointments or shifts that had not been filled were not recorded within this meaning it was not possible to see if capacity met demand in this respect. We were told this was due to begin in May 2016.

Waiting list trends showed a majority of services were meeting waiting time targets, however a number of service including podiatry, continence, diabetes and musculoskeletal services were consistently breaching trust targets.

Community services had a model of integrated community teams across health and social care to ensure people received joined up working. There were multiple languages spoken across the two boroughs and the need for interpreters was understood by staff. Staff were from diverse backgrounds, reflecting the communities they served and were able to draw on their language skills as required.

Planning and delivering services which meet people's needs

- Community services had a model of integrated community teams across health and social care to ensure people received truly joined up working. The aim of the service model was to improve patient outcomes and experience through bringing existing community services from health and social care into a more combined way of working. The aim of the model was to reduce the number of different professionals that patients needed to interact with, and reduce duplication of work, with an increased focus on personalised care and self-care.
- The RRRT was an integrated health and social care service for adults, primarily older people, which was commissioned by Richmond clinical commissioning group (CCG) and delivered in partnership between Hounslow and Richmond Community Healthcare NHS Trust and the London Borough of Richmond upon Thames.
- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- Staff we spoke with told us they had developed good working relationships with commissioners, other providers and stakeholders to ensure multi-disciplinary working and continuity of patient care. For example, the RRRT was an integrated team. The team had social workers provided by a S.75 risk sharing agreement with the local authority. The team was established in October 2015 with the aim of preventing people from being admitted to hospital, unless this was absolutely necessary. Staff told us the team was learning from the Hounslow ICRS team's model of care and treatment.
- The RRT social workers were funded by the local authority; Occupational therapists were funded by Richmond borough; physiotherapists, nurses, dieticians, and rehab assistants were funded by the trust.
- Senior managers told us the trust worked very closely with both the CCG and held regular meetings with the local authority to review population data, disease prevalence and service modelling to reflect the local needs identified in the Richmond Joint Service Needs Assessment (JSNA); this is an assessment that pulls together information about local health and care and support, and is a vital tool to help plan future services.
- A psychologist from the community learning disability team was working with a local mental health trust to develop an improving access to talking therapies (IAPT) pathway for people with learning disabilities.
- The community learning disability service were working with the local authority to develop a transition pathway for young people with learning disabilities into adult services.

Requires improvement

Are services responsive to people's needs?

- We saw there were extensive displays and leaflets covering condition-specific topics, general health advice and signposting to local health and social care services.
- The RRRT team had access to the local authority Framework- I electronic recording system. The team manager told us this was due to the team having a brokerage function, with some care being funded by the local authority.
- The neuro rehabilitation team used a 'goal attainment scale' (GAS) to monitor people's progress. This involved people being screened using specific, measurable, attainable, relevant, time limited, (SMART), objectives, and a scored at the beginning and end of treatment.
- The neuro rehab team told us they produced a number of reports during the year which were related to their key performance targets. The reports were monitored by the finance contracts manager.

Community nursing

- Senior managers reported there was a constant challenge when referring to the needs of two different boroughs. However, the teams always put the patient first. Each patient was seen as an individual and treated on the merit of this. It was also a challenge to reflect the differing needs/requirements of two commissioners. There was a standardised structure across the two boroughs with one set of policies and procedures in place for both. There were multiple languages spoken across the two boroughs and the need for interpreters was understood by staff. Senior managers reported that staff were from diverse backgrounds, reflecting the communities they served and were able to draw on their language skills as required.
- Senior managers told us there were two separate commissioners requiring two separate relationships and meetings. The associate director attended monthly performance and safeguarding meetings with each Clinical Commissioning Group (CCG). Feedback regarding changes were then disseminated to the teams.
- Senior managers reported that the need for dementia care was greater in Richmond which was reflective of the community demographic. There were two specialist dementia nurses in Richmond and in Hounslow this service was provided by the mental health trust. There was a training programme across the organisation for dementia. All patients were screened and referrals to specialist services were made where appropriate.
- There was commissioning for quality and innovation (CQUINs) around dementia in place in both boroughs. In Richmond it was nearing the end of its second year and in Hounslow the end of the first year. The CQUIN was around identifying dementia patients and training staff regarding dementia.
- Another CQUIN was concerned with working with nursing homes and commenced in April 2015. It centred on supporting nursing homes with education to manage conditions rather than send residents to A&E.
- There were joint meetings in place with the DN teams and mental health care co-ordinators for improved joint team working around mental health. In Hounslow there was a primary care nurse who was contacted for advice and referrals can be made too.
- The trust successfully bid for systems resilience monies to fund GP and acute physician support to the RRT and ICRS teams to increase the scope of patients who could be care for by the team. This support was being continued in 2016/17.
- The matron in Richmond carried out weekly ward rounds with GPs. In Hounslow there was joint working with GPs as part of a multidisciplinary meeting in GP practices.
- Rapid response teams were attached to the local community hospital, working with not only Teddington Memorial Hospital but also local acute hospitals. The teams were made up of nurses, physios, OTs and social workers.
- The use of IVs in the community was reported by senior managers as ever expanding. IV flushing was undertaken with a local acute hospital as outpatient appointments. The trust was working with the acute provider to move this service into the community.
- There was a leg ulcer clinic on a Wednesday run by one member of the team with support from tissue viability as needed. The matron of the practice saw mainly respiratory patients and also the keeping well team for managing stable long term condition patients.

Requires improvement

Are services responsive to people's needs?

- Patients with learning disability were seen at clinics with carers. For convenience they were given appointments first thing in the morning or the last of the day. Patients were not seen on their own. The work was working with carers, for advocacy, familiarity and knowledge of patients.
- Keypad codes to patient doors were on system one and are then written on patient list for the day.

Equality and diversity

- Staff we spoke with told us they have received equality and diversity training as part of the trust's corporate induction.
- Staff we spoke with were aware of the need to obtain interpreting services on an appointments basis. Staff told us interpreters would provide face to face services, but this needed a booked appointment. This meant that people whose command of English was insufficient to ensure they could communicate their needs, symptoms and experience, had access to support by appointment. Staff also told us Trust staff who spoke other languages would sometimes provide interpreting services.
- Staff told us people with a sensory impairment had access to the Trust's sensory services team. Staff told us they could book appointments to make joint visits with the sensory impairment team.
- Staff at the RRRT team told us dementia awareness training was mandatory for all staff that had direct contact with people who used services.
- Staff told us all of the trust's printed information was available upon request in any language from the trust's accessible communications team.
- The neuro rehab team worked in partnership with Hounslow community partnership integrated neurological services. This was a partnership of organisations working together to maximise the health and wellbeing of vulnerable adults in Hounslow.

Community nursing

- Senior managers told us there was an equality and diversity policy in place. It detailed the statutory and mandatory training required. Reasonable adjustments were met.
- Based on the local population at the last census, Hounslow reported a much higher minority ethnic population as a proportion of the total (47% to 53%), close to the London average, while Richmond reported a much lower minority ethnic population as a proportion of the total (14% to 54%), closer to the England average.
- We found an example where the DN team were supporting an elderly stroke patient who was not able to speak or understand English. Interpretation was needed and carried out by family members. An interpreter was used at the beginning of home care but had not been used on any regular basis that would have ensured patient understanding with ongoing care.

Meeting the needs of people in vulnerable circumstances

- The community learning disabilities team provided a range of services for people with a learning disability. We saw a range of leaflets had been produced in easy read format by the learning disabilities team and were readily available across the trust's locations.
- The community learning disabilities team had a challenging needs service, this included a behaviour analyst and behavioural assistant. The team provided intensive support for people with challenging behaviour in their own homes in the short to medium term.
- Referrals to the podiatry service were received at central administration hub and were triaged. Staff told us commissioners hadn't considered the numbers of follow up appointments when assessing the team's capacity. Staff told us waiting lists were as a result of follow up appointments. Staff told us they had benchmarked the service against the national average and the team were doing more appointments than the national average. For example, staff at the service showed us a document where the national average contacts 2013 to 2015 was 1845, the team had actually had 2029 contacts in this time. Staff told us the reason for the high demand on the service was follow up appointments. Staff said if they saw patients to timescale, this would result in delays in other people's follow up appointments.

Access to the right care at the right time

- We viewed the Richmond waiting list trends analysis spreadsheet for April to December 2015. We found the

MSK service was meeting the five days waiting times target for routine appointments. However, the service had not achieved the five days target for block contract urgent referrals from June to December 2015.

- The community neuro-rehab team had met the urgent two week waiting time for urgent referrals and the six week waiting time for routine appointments in the period June to December 2015.
- Richmond podiatry team had not met the ten days waiting times for 'any qualified podiatrist' routine appointments; we saw from viewing the trends analysis spreadsheet for April to December 2015 the waiting time for a routine appointment was an average of 19 days.
- The RRRT team worked in partnership with the Richmond GP alliance, this was an initiative to improve access to primary care services for people registered with a Richmond GP.
- Referral for the RRRT was for people who were assessed as safe to be managed at home via the single point of access (SAP). For a two hour response RRRT required a clinician to clinician exchange of information and care plan, including information such as people's medical histories. Paramedics could also refer people directly to the team following a risk assessment.
- The RRRT team had a clinical triage team at the SAP. This involved the team collating information about people's needs from District Nurses, GPs, Community Matrons and other specialist services. Services were prioritised on the basis of people's clinical needs. Rapid two hour response was always made from triage. However, for none urgent responses the team's business support administration team would look at the team's capacity and make appointments on the basis of people's needs.
- Staff at the RRT team told us that people were always informed if their care was delayed by staff being delayed at an earlier visit or due to traffic congestion.
- The RRRT team's triage team was med up of social wokers, OT's, physiotherapist and nurses. Staff told us they did not have a checklist to assess people's eligibility to receive a service, but use their professional judgment.
- The neuro rehabilitation team had a screening form that was processed by the single point of access (SAP). Staff told us referrals were mostly from neurologists and GP's. People who were known to the service could also self-refer.
- Waiting list trends were reported on a monthly basis for the two trust boroughs; Hounslow and Richmond. A number of community services including musculoskeletal, diabetes, podiatry, falls and bone health, continence and tissue viability were reported on.The February 2016 report showed the year to date and showed urgent and routine waiting times RAG rated against trust targets.
- While a majority of services showed a green rating in Richmond for meeting waiting time targets, routine podiatry and continence waiting times had missed contracted targets set by commissioners throughout the year, while diabetes and falls and bone health also showed breaches.
- In Hounslow continence and musculoskeletal services were consistently breaching trust targets. For the current month reported, February 2016, wheelchair services, phlebotomy and continence were the 3 Hounslow services rated as red as not meeting contracted waiting times.
- In Hounslow continence and musculoskeletal services were consistently breaching trust targets. For the current month reported, February 2016, wheelchair services, phlebotomy and continence were all rated red as not meeting trust waiting time targets.

Community nursing

- Senior managers reported that the target for the number of contacts for nursing services had increased for 2015/16. In Hounslow the target was 8000 patients seen per month and in Richmond the target was 7300 patients per month. Both of these targets were surpassed and additional funding secured from the CCGs. Community nursing services was a high demand service which was increasing. We were told that the trust leadership were they aware of the increase in nursing demand through the performance and quality structure.
- The adult nursing response times for completed referrals for quarter 3, (October – December 2015) showed the following: The proportion of emergency

referrals seen for first appointment within 2 hours was 83%, which met the trust target of 80%. The proportion of urgent referrals seen for first appointment within 24 hours was recorded as 98%, significantly above the trust target of 80%. The target for seeing all routine referrals for first appointment within 48 hours had been missed by a significant amount every month with average of 50% against the trust target of 80%.

- Patient visits were categorised depending on complexity, as one hourly and half hourly or less, and staff were allocated accordingly. Geography was also taken in to consideration. Patient facing time was four to five hours per day with the rest spent on travel and administration. Team leaders triaged new referrals and allocated as appropriate. Average team caseloads were at 250 to 300. Handover times were between 1pm and 2pm. All staff held a trust mobile phone to communicate and allocate work outside of the hand over times.
- The safe staffing tool projected the shifts that would be required for each team based on acuity. Agency staff were not sought until at least two or three shifts were not covered per team. Senior managers felt that the DN teams were able to flex to meet demand and worked their caseloads to meet needs. Missed appointments or shifts that had not been filled were not recorded. It was therefore not possible to see how the trust could assure themselves that they knew how many shifts went uncovered, how many appointments were missed and if capacity met the demand of the service. We were told this was due to begin in May 2016 and that System One would also be used in the future to more accurately predict the number of staff needed for each shift.
- We observed a referral process, where referrals came from the Single Point of Access to the administrative lead who contacted the senior nurse if it was deemed urgent, for advice on who to give the referral to. The matron came in twice a day, in the morning and at lunchtime to oversee triage and administration then outlined a care plan on System One. This was put on the planner according to nurse allocation. Administrators then telephoned the patient to agree the visit date.
- We found many practical examples of patients receiving timely and integrated care. For instance:An elderly patient with a wound on their hip had the tissue viability nurse involved in the patient's care, working in conjunction with the DN service. A podiatry visit was planned for tomorrow, and hospital appointments were also planned as part of the package of care. We accompanied a nurse on their visits for assessments of patients. They were allocated four visits for the morning; one hour per assessment visit. On a visit to a patient with a leg ulcer that required daily dressing, the DN told us they felt the TVNs were supportive of the team and were happy with the access they had to other agencies for effective care. Dermatology were also involved to discuss treatment, working alongside the DN team. In the Hounslow integrated community response service, referrals came from GPs, social services, hospitals and self referrals from patients and family. Patients normally stayed with HRCS for a week. If health if their health was fluctuating or a new issue was found this could be increased. Patient safety and stabilisation was described as key. One visit was concluded with a discussion with the patient's GP about blood pressure, an eye problem and pain control as well as an occupational therapy referral for poor rails and bathing in view of falls.
- Due to staffing issues combined with demand and capacity it was reported that patients remained with the tissue viability team until wounds had healed as patients were unable to access practice nurses and DN clinics. We were told the service needed redesigning as a support service. A band 3 was being recruited to collect data on healing rates for leg ulcers. Current data for tissue viability was available but not clear in the community for DN patients. The plan was to have a TVN in some community clinics. Waiting lists were currently four to six weeks so patients were offered basic management advice with triage and pathways identified.

Learning from complaints and concerns

- Information regarding the Patient Advice and Liaison Service (PALS) and how to contact them was displayed in prominent areas in all the clinics and health centres we visited.
- The community learning disability service had an easy read complaints policy for people who used services.
- Staff at the RRRT team told us the team always tried to address complaints or concerns immediately to see if they could be addressed by the team. If It could not be resolved by the team, staff told us people would be

given the contact details of the patient advice and liaison service (PALS). We were shown the information pack people received from the RRRT team, this included a PALS information leaflet. Staff added that the RRRT team did not get many formal complaints.

- Staff told us the learning complaints committee regularly reviewed concerns and complaints and identified learning from these. Senior managers gave us an example of a theme being identified in regards to people receiving information on financial charges for some social care services. This had resulted in staff receiving further training on services which would incur a cost to people using services, to enable staff to be better informed.
- A person we spoke with told us they had complained to the wheelchair services on one occasion. The person told us they received and apology from the service and they were happy with the manner in which their complaint was dealt with.

Community nursing

- Senior managers reported there were few complaints. Team leaders called patients following a complaint or an expression of dissatisfaction to see what the issue was, with an aim to resolve it. This would also entail a home visit to resolve it if needed. All complaints were discussed in team meetings for learning.
- On a home visit, a patient's wife told us they felt the care given by the DN service was excellent and felt fully informed of the plans of care. They told us they were happy to speak up to speak to the team members if there were any concerns or queries.
- On another home visit a patient told us they had the contact details of the management of the service and were aware of how to make a complaint. They told us they had reason to use this contact in order to arrange support for having injections due to a needle phobia. They felt the service was working well for them and were happy with the process of being able to speak about what they felt unsure about and to have this resolved to their satisfaction.
- On a home visit to a patient with a leg ulcer, the patient told us they knew how to complain about the service if they ever felt the need.
- A leaflet was left with patients that explained the friends and family test, the role of PALs as well as complaints. It was also explained to the patient. Contact details for DN and information regarding service was also provided.

Good

Are services well-led?

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

Summary

Middle managers felt there was clear leadership at executive level and managers told us the chief executive was approachable. However, some staff told us directors were not very visible in the local offices. Staff generally reported a positive culture in community services.

There were clear governance processes and lines of accountability in place. The community nursing leadership team were all relatively new in post but meaningful progress had been made on improving the quality and sustainability of the service. The Community Nursing Service Action Plan identified 18 actions that monitored progress on key areas of performance and progress was regularly monitored and updated. There were two newly created practice development lead posts. The leads stated clear goals and aims for the coming year.

Service vision and strategy

- Staff were aware of and able to articulate the trust's vision.

Governance, risk management and quality measurement

- We found there was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff.
- Community services had a divisional risk register in place, there were systems for formally signing off action plans or removing risks from the register which ensured that matters were managed appropriately to their conclusion. However, we saw that there were items on the register that were no longer deemed to be a risk that had not been removed from the register.
- Staff at the podiatry service told us they were struggling to have the time to do their quality assurance, and acknowledged that this required improvement.

Community nursing

- The divisional manager for community nursing reported to the associate director, who reported to the 'director for operations clinical excellence governance and quality', who sat on the trust board. The reporting structure consisted of monthly quality and governance meetings that looked at strategic direction, serious incidents safety thermometer, review, themes and filtered down to team level. Monthly performance meetings looked at targets. Teams had monthly meetings to look at activity, incidents and learning as well as staffing levels, recruitment and safety thermometer. There was a managers information report that fed into managers' meetings and monthly redesign meetings where teams discussed ongoing development issues with the divisional manager for community nursing. Team leader meetings, at band 7 level, followed managers meetings.
- The Community Nursing Service Action Plan identified 18 actions that monitored progress on key areas of performance. They included nurse recruitment, staff turnover, agency spend, clinical supervision, medication incidents, safeguarding alerts and pressure ulcer rates. Progress was regularly monitored and updated.
- An audit regarding leg pressure ulcers had been completed and published in February 2016. Its aims included: to identify if they are any gaps in leg ulcer prevention and treatment, evaluate the number of patients receiving treatment in leg ulcer clinics and assess community nursing staff training/developmental needs. Recommendations included: training through accredited courses and able to demonstrate competence and to review and redesign the provision of leg ulcer care across the trust.

Leadership of this service

- Middle managers felt there was clear leadership at executive level, even though they acknowledged their had been changes at executive level. Managers told us the chief executive was approachable and the chief executive had visited the community learning disability service. However, some staff told us they felt Directors were based at Thames House and not very visible in the local offices.

Good

Are services well-led?

- Local team leadership was effective and staff said their direct line managers were supportive.
- Staff in all the therapy services we visited felt their line managers were supportive and accessible. Although they did not often encounter senior management, they felt they knew how to access them if required.
- Staff at the community learning disability team told us the service manager provided outstanding leadership.
- Most Band 5 and Band 6 staff we spoke with told us they felt comfortable in their role and well supported in their development.

Community nursing

- The whole leadership team for community nursing were relatively new in post. The longest serving member of the leadership team had been in post for 18 months. It was acknowledged that there had been a high turnover of staff, however it was felt that the team was now in place, were stable and had direction. It was felt the model now had sustainability which can be developed. All band 7 nurses were now in post. The leadership team told us the aim going forward was to look at staff from within from the ground floor up, enable staff to 'upskill' at all levels. The newly created practice development team were to lead on this work. The main responsibilities of the practice development team was support, education, problem solving and investigation.

Culture within this service

- Generally therapy staff spoke positively of the organisation, their teams and their work. Staff reported that morale was high across community adult services therapy teams
- Therapy staff said they were proud to work for their team and enjoyed their role.
- All the therapy staff we spoke with were positive about integrated services and felt positive about their role and contribution in this.
- Staff generally reported a positive culture in community services. However, podiatry staff at Hounslow told us staff morale was low due to administration staff having been relocated to the trust's central hub. Staff told us the administration staff had known their patients and the loss of the administration staff had an impact on the service's patient flow.

Community nursing

- The leadership team reported that the trust was small which made it easy to communicate effectively with all levels within the organisation including with the executive team. The director of governance, quality and nursing chaired the quality and safety group, infection control meeting and also attended some team meetings. The culture was reported as open, friendly and approachable which is reflected within the staff survey results. There was low staff sickness rates of 3%. It was felt that "they knew what was good and what was not so good". Where incidents were identified there was a "no blame" culture to aid learning. It was felt that everyone felt accountable for the service they provided.

Public and staff engagement

- Senior managers we spoke with told us staff had access to 'away days', these were days where staff could look at team performance.
- Staff told us they received regular newsletters via email.
- Local patients and staff could nominate individual staff members and teams who they thought embodied the trust's mission, vision and valued in their work. The RRRT team had received a runners up award in 2015 in the category of 'outstanding clinical team.'

Community nursing

- As at January 2016 the current recommend rate from the Friends and Family Test (FFT) for community nursing was 94.4% which was average for the year. However, the response rates were on average around 1% and so caution is required when interpreting these results as the recommendation rate is based on a very small proportion of the total number of service users.The response rates for quarter 3 were on average around 2%, which represented 202 patients. The trust told us they considered the views of over 200 patients to be valid.
- The Community Nursing Service Action Plan identified 18 actions that monitored progress on key areas of performance. Aims for the Friends and Family Test (FFT) were stated as 'Achieve minimum 90% FFT for people who have accessed HRCH services who report they would recommend the service to friends or family should they need similar treatment. progress is currently stated as: February position against trust

objective was 97.6% for the community nursing service. District nursing progress against this target is now being monitored. Teams each have a Meridian hand held device to support response collection and the teams have been set a target of getting feedback from 5 patients per team per week. Review of this approach has shown that this has been more appropriate in specialist services such as tissue viability. Majority of DN service has reverted to using cards, with some teams using admin support to telephone patients following discharge to complete FFT.

Innovation, improvement and sustainability

- Staff at the neuro rehabilitation team told us they had submitted a bid to the Trust's 'Dragon's Den' initiative. The bid was supported and the team received funding to create an online system where people could monitor their progress via a series of computer games.

Community nursing

- The two practice development lead posts had been created within the last three months. The leads stated their goals and aims for the coming year. They included publishing the preceptorship pack which would soon be available to staff as was the student nurse induction pack. They were also starting a 'deep dive' focussing on pressure ulcer care and prevention. There was a pack being developed to leave in patients' homes regarding self management, care planning, with contact numbers, a PALS leaflet, a 'how to complain leaflet', a Friends and Family Test sheet and SSKIN info. They had also planned nurse training for the coming year with the sessions at the DN's bases so that it was easier for them to attend. Practice development leads planned to develop the competency framework so that it dovetailed into the appraisal process along with revalidation and PDP. Practice development leads also planned to support team leaders to do safe caseload reviews in the next few months.