East London NHS Foundation Trust

RWK

Community health services for adults

Quality Report

East London NHS Foundation Trust
Trust Headquarters
9 Alie Street
London
E1 8DE
Tel:020 76554000
Website: www.elft.nhs.uk

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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)
RWKG7	Trust Headquarters		

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

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

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall we rated this service as **good** because**:**

- Patients and carers fed back that staff were very professional, caring and supportive.
- Access to the services were well managed through a central point of access who were able to direct patients to the most appropriate team.
- There was evidence of appropriate treatment across community health services for adults that were delivered in line with national guidance and best practice.Staff had access to evidence-based advice, information and guidance. Staff with specialist skills and knowledge were used by community teams to provide advice or direct support in planning or implementing care. Teams worked together in a coordinated way and made appropriate referrals on to specialised services to ensure that patients' needs were met. Quality improvement work had been used to reduce the number of patients acquiring a grade 2, 3 and 4 pressure ulcer whilst using the service.
- Staff could access interpreters and translation services, with patient literature available in languages used by people in the local community and in accessible formats. Staff had a good understanding of the different cultural needs and backgrounds of patients.
- Most staff in adult community services were positive about their local and trust leadership. All staff were proud to work for the trust and positive about their work. There was a governance structure that enabled managers and senior managers to appropriately monitor and review the quality of service provision.

However:

- There was an inconsistency in the completion of healthcare records. Assessments, physical health observations, care plans and risk assessments were not always completed and readily available to staff working in the services. This meant that nursing staff may not always have a clear understanding of the risks or a patient's health status when giving treatment.
- Some staff were not aware of the term 'duty of candour' although they were able to describe how they applied this in practice.
- Whilst the trust had systems in place for identifying and reporting safeguarding risks, to safeguard people from abuse, staff were not always able to decide the threshold for making an alert.
- The services were making very limited use of outcome measures as a way of evaluating the progress being made by patients.
- Staff understood the importance of obtaining the patients' consent to treatment. Bespoke training had been provided and staff had access to trust MCA advisors. However, some staff lacked confidence in using the Mental Capacity Act.
- Patients were offered a morning or afternoon appointment slot by the district nurses but would have preferred more information about the time of their appointment.
- Some patients were waiting a long time to receive a service from the wheelchair team, although this had been identified on the directorate risk register and actions to improve the service were in place.

Summary of findings

Background to the service

The East London NHS Foundation Trust (ELFT) provides adult community services in Newham to support people to stay healthy, manage their long term conditions, to avoid hospital admission and following discharge from hospital to support them at home. Services are provided from health centres, clinics and in people's homes.

Adult community health services available in Newham are provided through the extended primary care team. This has a single point of access which operates for twelve hours, 7 days a week.

Patients are then signposted on to a number of other teams depending on their individual needs. This includes teams providing a rapid response, hospital in-reach and early supported discharge.

There are four community health teams consisting of district nurses, physiotherapists and occupational therapists and these were the main focus of the inspection. Each of these teams has an average caseload of 400 patients at any one time. The teams can see patients for varying lengths of time, up to three times a day.

The inspection took place mainly at the East Ham Care Centre and Vicarage Lane Health Centre where many of the staff were based.

Our inspection team

The team that inspected adult community services, consisted of two CQC inspectors and four specialist advisors with experience of nursing, tissue viability and therapy services.

Why we carried out this inspection

This was a scheduled comprehensive trust inspection.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

During the inspection the inspection team:

- visited a number of teams based at the East Ham Care Centre and Vicarage Lane Health Centre
- spoke with a total of 57 community nurses and allied health care professionals, managers and administration staff
- spoke with 15 patients and their relatives
- looked at 27 patient records
- observed how staff cared for patients at clinics and during home visits

Summary of findings

- reviewed meeting minutes, operational policies and staff records
- reviewed patient friends and family test information received from patients who used trust community services
- reviewed performance information from the trust about the services

What people who use the provider say

We spoke with 15 patients and received positive feedback about the care and treatment from most patients we spoke with. Two patients told us they had a "very quick response in an emergency" and staff were friendly and helpful.

The trust used the NHS friends and families test amongst other methods to gather feedback from patients. Of the patients that responded 92% said they would recommend the service to friends and family. Most patients we spoke with said the service was good and staff listened to their concerns.

Overall themes for improvement included, communication, and several patients said they did not know when nurses would arrive and sometimes they did not come when they should. For example, two patients were unhappy that they did not know when community nursing staff would arrive and they did not always get informed the nurse was not coming until they rang to find out where they were. Patients in some clinics said they were long waiting times to be seen and they were never told how long they might have to wait. However when they were seen they received a good service.

Patients and families who we spoke with during our onsite inspection told us that staff were caring and were always approachable. Patients were able to feedback in a number of different ways for example, by phone and in writing. The trust were considering extending the use of electronic feedback collection devices such as tablets to gather feedback from patients across the community nursing services.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure all patient records are maintained appropriately. This is to ensure that patients have the necessary assessments, that assessments have been reviewed at appropriate timescales, that records of physical health observations are available and care plans in place. This is to ensure that district nurses in particular, deliver the appropriate care or recognise when the patients needs are changing and if it is necessary to involve another care professional such as a tissue viability nurse.

Action the provider COULD take to improve

- The trust should ensure that staff are all familiar with the term, 'duty of candour' and their responsibilities, even though they were applying this in practice.
- The trust should ensure that staff have greater clarity of the thresholds for making safeguarding alerts.
- The trust should ensure that staff working in the community health services for adults have an improved confidence in using the Mental Capacity Act.
- The trust should ensure that staff working in the community health services for adults make more use of outcome measures to monitor the progress made by patients using the service.
- The trust should aim to provide patients with more information about the time of their district nursing appointment.
- The trust should continue to improve the waiting times for a wheelchair service.
- The trust should ensure staff all have opportunities to attend team meetings on a regular basis.

East London NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as **requires improvement** because:

- The quality of the care records were very poor. This meant that some patients appeared to have not had all the necessary assessments, that assessments had not been reviewed at appropriate timescales, that records of physical health observations were not available and care plans were not in place. This meant that there was a risk that district nurses in particular would not deliver the appropriate care or recognise when the patients needs were changing and it was necessary to involve another care professional such as a tissue viability nurse.
- Staff were not applying consistent thresholds for making safeguarding alerts.
- Whilst staff could describe a culture of openness and informing patients of incidents, some were unfamiliar with the term duty of candour.

However:

- Community nursing staff had access to specialised equipment to meet patients' needs when required.
- Staff had taken steps to reduce the numbers of patients acquiring grade 2 pressure ulcers.
- Staff were maintaining good standards of infection control when delivering care.
- The service had arrangements in place to provide continuity of care in circumstances such as extreme weather.

Safety performance

- ELFT participated in the NHS Safety Thermometer scheme used to collect local data on specific measures relating to patient harm and 'harm free" including falls and pressure ulcers. Data were collected on a single day each month to indicate performance in key areas. Between March 2015 and March 2016 the trust recorded 14 new pressure ulcers acquired for patients in receipt of a district nursing service and 27 patients experiencing a fall. Many more patients had pressure ulcers, but these were present when the patient began treatment.
- The service monitored safety information through regular clinical governance meetings and by monitoring

Requires improvement

Are services safe?

incidents including pressure ulcers, falls and medication errors. Overall, due to a range of measures including assessments and care planning, there had been a 60% reduction in grade 2 ulcers reported in the last year.

- There were no 'never events' reported between May 2015 and April 2016. Never events are incidents determined by the Department of Health as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There were 10 serious incidents requiring investigation in adult community health services between February 2015 and January 2016 mostly relating to pressure ulcers.

Incident reporting, learning and improvement

- Staff knew how to report incidents and were aware of the online reporting tools and procedures they had to follow. This process was embedded in teams. The trust procedure was for all pressure ulcers to be reported regardless of where the the patient was receiving care when they originated.
- There were arrangements in place for staff to discuss learning from incidents as part of team meetings and at learning lessons seminars. Staff awareness of this varied.
- The trust had made changes as a result of learning from incidents. For example pressure ulcer improvement facilitators had been introduced. Most of the community nurses we asked were unable to give us examples of where changes to patient care had taken place as a result of an incident. Two community nurses said that following an incident there had been changes in lone working arrangements to keep staff safe. Staff said incidents sometimes took a long time to be investigated and they did not always get feedback.

Duty of candour

- Most staff we spoke with did not understand the term duty of candour. However, examples they gave about how they would respond when incidents occurred confirmed staff understood some of the principles of ensuring they informed patients when things went wrong and were open, honest and transparent in their communication.
- A trust wide annual internal audit report dated April 2016 on duty of candour found that a trust wide policy and procedure was being developed at the time of our inspection. A quality improvement project was looking at how best to monitor duty of candour.

Safeguarding

- All staff had completed safeguarding adults training.
- Community staff were knowledgeable about safeguarding procedures and knew who they would report any concerns to. Information of safeguarding procedures was displayed. However we found not all staff were clear about the thresholds for when they should report concerns. We looked at two patient records where we identified safeguarding concerns and saw these had not been reported. We discussed with the lead nurse who knew about the situation. They told us they would report one as a safeguarding concern immediately and would follow up the other with a visit as the situation had been ongoing for some months already.

Medicines

- There was a trust community health pharmacist who could be contacted for any medicines queries, although there was not pharmacy input directly for the teams. Nurses said they often sought advice from GPs or community pharmacists where needed. The trust had recognised that they needed to provide more pharmacy support to the teams and were trying to implement this within the next three months.
- Medication training was provided by the trust and competency frameworks were in place to ensure staff were compliant with trust policy. Managers told us that if any issues were raised training additional support would be arranged where needed.
- We observed nurses administering medication via a subcutaneous syringe driver following best practice in medicines management.
- Community adult services had a number of nurses who could prescribe and adjust doses for certain medications for patients. Prescribing was within their scope of practice and agreed formularies and guidelines. Nurses had to be registered to receive FP10 prescription pads.

Requires improvement

Are services safe?

Environment and equipment

- There was an electronic system in place for ordering specialist equipment. This ensured a quick response and meant there was a clear audit trail. Teams were kept updated regarding any new equipment available.
- Bespoke specialist equipment such as in-bed sleep systems were available to support patients' independence.
- There was a system in place for servicing beds, hoists and wheelchairs.

Quality of records

- We looked at 27 electronic and six paper records. We looked in detail at patient electronic records (PER) and where we had seen patients paper records we compared information on the PER with information on paper records.
- Over 50% of records were missing an assessment to identify risk of developing a pressure ulcer called a waterlow score. Skin integrity risk (SKKIN) assessments for patients at risk of pressure ulcers were not completed for over 50% of patients. Where assessments were in place many had not been reviewed within the appropriate timescales to see if the patient needs had changed. The trusts own audits showed a completion rate of over 70% for waterlow assessments and over 50% for SKKIN.
- Person centred care plans were in the process of being developed by the trust and so these were not yet available in the patient records.
- The district nursing service worked closely with the tissue viability service. Pressure ulcer treatment plans were in place where the tissue viability specialist nurse had been involved. Three patients had a pressure ulcer treatment plan. However, on checking the PER, one had been updated by the tissue viability nurse 12 days earlier and nursing staff were not following the current plan as it was still on the electronic system. We saw three examples where records showed that patients' deteriorating pressure ulcers had not been referred to the tissue viability nurse as soon as best practice guidance suggested they needed to. One community nurse confirmed this as they had just returned from visiting the patient and were going to refer the patient. In two other examples we saw leg ulcers treatment plans where the compression bandage formula had not been followed. Staff had recorded what they had done but that was not what was written on the treatment plan.
- Three paper records did not have consent to share information signed by patient.
- Records did not always reflect the patient's current health conditions and risks and had not been updated.
- We did not see any moving and handling risk assessment in six patient paper records we reviewed. Four patients were unable to go out and needed assistance/equipment to mobilise.
- Physical health observations such as recordings of blood pressure and temperature were sometimes missing. These omissions meant that staff did not have an accurate baseline recorded from which to measure future changes in patients' health status and to inform decisions about subsequent care.

Cleanliness, infection control and hygiene

- The clinic environments were clean and staff followed infection control procedures. Hand hygiene gels, paper towels and rubbish bins were provided.
- Staff demonstrated a knowledge and understanding of infection control. Staff used techniques to prevent spread of infection including hand-washing and use of personal protective equipment such as gloves and aprons. We observed nursing staff following recommended infection control practice in the nursing care of a patient who had an open wound.
- Nursing staff disposed of infected clinical waste in identified bins which were collected from the patient's home.
- Trust wide regular hand hygiene audits were carried out with a compliance rate of 100% in April 2016.

Mandatory training

- Statistics from the trust for community adults showed that overall 91% of staff had completed mandatory training in April 2016 although there were variations between teams (especially for small teams) and training topics.
- E-learning materials had been developed to meet mandatory training needs. These included training in

manual handling,safeguarding level one, equality and diversity and information governance. Staff in the different teams described good access to mandatory training.

Assessing and responding to patient risk

- Nursing staff were expected to complete a waterlow assessment to identify patients at risk of developing a pressure ulcer. Completion rates were audited weekly for new referrals.
- The pressure ulcer and management plan clinical practice guideline (2014) stated 'patients who are at risk of developing pressure ulcers should have an individualised SSKIN bundle prevention plan'. We found that patients that met these criteria that had been seen by a specialist tissue viability nurse did have a SKINN bundle form completed. Patients who met the same criteria who were not referred to the tissue viability nurse did not always have a prevention plan. This meant staff were not following trust guidelines in the management of risk.
- Also the guidance said that patients with a pressure ulcer should have a photo of the wound so it could be monitored. This was done for patients seen by the tissue viability nurse, but many were only seen by the district nurses and did not have this in place. This was being reviewed by the trust.
- Most of the 27 patient records we looked had different staff visiting at every appointment with little continuity of staff. Two patients we spoke with confirmed they always had different nurses.

Staffing levels and caseload

- Vacancies for district nurses were on the trust board assurance framework but had reduced from around 30% to 7%. This was being addressed through ongoing recruitment, trying to use agency on longer term contracts, seconding a second tissue viability nurse to the team from a ward and providing the team with additional support to manage incidents and complaints.
- Most teams were using temporary staff on a weekly basis and some had been in the team for long periods. Staff told us they were using bank and agency staff every week to support teams and this was because referrals fluctuated and they needed to ensure they had enough staff to manage the workload and skills required. Community nurses mitigated the impact on patients by trying to use the same agency staff. Three agency staff told us they had worked in teams for over a year.
- Between January 2015 and December 2015, out of a complement of 328 staff, 52 had left. This was a turnover of 15%. Various reasons were given for this, including nurses not happy with workload and pay differences internally with staff having the same role and having different pay scales due to decisions made when recruited. The trust is close to other trusts that could offer higher levels of London weighting as they were located in an inner London area.
- Changes in the configuration of the teams were taking place and this had impacted on therapy services which was resulting in staff changing jobs. Locum staff were being used to fill vacant therapy posts in the meantime.
- Community nurses told us their caseloads were team based. These meant patients were likely to be visited by different community nurses during their treatment. Nursing staff told us pressure of work meant they were prioritising palliative care, pressure care and patients needing help with medication.
- Staff told us that they were very busy and this meant they were unable to spend as long as they would have liked with patients. Managers said staff often worked late, particularly if a patient had a late discharge from hospital. This meant the late shift nurse would not finish at 10pm and would stay until they had settled the patient and provided the care that was needed. Staff were able to request time off in lieu for the extra work. Two community nurses told us they would rather work additional time and ensure patients were seen within the trust target timeframes.
- Managers said they were reviewing the criteria for the community district nursing services and recognised they were providing a number of services, for example dressing clinics and home visits to patients who were not housebound and could go to their own surgery for dressings. Plans were in place to ensure the single access referral team would robustly triage referrals to ensure nurses visited only those patients that met the criteria they were commissioned to deliver by the clinical commission group.

Managing anticipated risks

Requires improvement

Are services safe?

- District nurses contacted patients by phone wherever possible to arrange a first visit. This was so they could assess whether there were any risks to do with the environment and discuss the reason for the visit. For example staff checked access to the property and whether there were animals at the property. They used the information to prioritise the timeframe for the visit and identify the most appropriate level of staff to visit.
- There was a lone working policy in place to support staff working out in the community. Staff were aware of the lone working policy. Staff had a mobile phone to access support whilst out on visits should they need it.

Major incident awareness and training

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

Good

Are services effective?

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

Summary

We rated effective as **good** because**:**

- The staff were delivering care in line with best practice, for example following the latest guidance on pressure care and diabetes foot health.
- The staff were mindful of supporting patients with pain relief and providing timely input.
- Staff had access to induction training, supervision and ongoing professional development.
- There was good multi-disciplinary working within the trust and with external bodies.
- Patients had timely access to services through a single point of accessed that directed patients to the most appropriate team.

However:

- The services could make better use of outcome mesures to evaluate the progress of patients.
- Staff did not always feel confident in using the Mental Capacity Act, although they had access to advice where needed.
- The trust was implementing a competency framework to ensure staff skills were regularly checked and additional training provided where needed. This needs to be completed.

Evidence based care and treatment

- The trust participated in and initiated a number of national and local audits. For example in assessment and rehabilitation, falls management and the national audit of intermediate care.
- National institute for health and care excellence guidance was used by staff. For example the latest guidance on the treatment of pressure ulcers and diabetes foot health best guidance was used when delivering care.
- There had been a programme of work within the trust to reduce the number and severity of pressure ulcers. This had led to a 50% reduction in the number of acquired grade 2 pressure ulcers across the teams since October 2014.
- The trust used telehealth technology to support people to manage their health condition, maintain their health and well-being and live independently. This was the use of technology to enable people to monitor their own long term conditions and this would identify when additional support was needed.
- The intranet was available to all staff and contained links to current guidelines, policies and procedures. Staff said they received regular trust bulletins and emails from managers

Pain relief

- In a multi-disciplinary meeting, professionals were observed discussing options for patients who needed support with pain management.
- The trust had a number of community nurses who were nurse prescribers. This meant they could adjust patient's pain medication prescriptions when it was needed and this helped patients to receive prompt care when they needed it.
- We saw examples of pain relief being considered during home visits and observed a home visit with a patient where options for pain relief were discussed with the patient and their family.
- Nursing staff said they would refer concerns about pain relief to the GP and if a patient required palliative care would discuss this with the local palliative care team who were another provider.

Patient outcomes

- Staff did not consistently use outcome measures to monitor and outcome a patient's progress.

Competent staff

- All new staff accessed the trust wide and local induction.
- Some staff raised concerns about a lack of hands-on moving and handling training although some had received training in a previous post. This had been put on the risk register but training dates were not yet available.

Good

Are services effective?

- All community staff had formal managerial supervision. Staff said that if they needed support or to discuss their work they could do this at any time with their line manager and other team members. Clinical supervision was more variable, especially for nursing staff, but could be requested where needed.
- Between January 2015 and 31 December 2015, 77% of staff in community adult's services had been recorded as having an appraisal. Rates varied across the services, for example in the community health teams 59% of central, 74% of south and 64% of north west community staff had received an appraisal. Regular agency staff also had supervision and could access training.
- The trust supported newly qualified nurses through the preceptorship and had developed strong links with a local university to train and develop nurses.
- Health care assistants had either completed or were in the process of completing the care certificate. This was a requirement for all new staff entering the NHS from April 2015 and aimed to equip health and social care support workers with the knowledge and skills which they needed to provide safe, compassionate care.
- Staff completed training to ensure they were competent and following the training they were deemed competent to provide the care and treatment needed. The trust had recognised that more support was needed to ensure the competency of staff and they were putting in a competency framework to ensure staff skills were appropriately checked and additional support provided where needed. This reflected the findings of the inspection where there were some concerns about staff competency. For example, one member of staff was observed incorrectly applying compression bandages for a patient with a leg ulcer, that could have increased the risk of skin deterioration.
- Managers told us there was no formal record of agency skills or competencies. Agency and bank staff were observed carrying out treatment to ensure they were competent. This was also not reviewed on a regular basis.
- All staff said they could access additional specialist training. For example access to leadership development and post graduate courses. Staff could apply and were supported with time off work for study and adjustments to working patterns if required.
- Additional specialist training was also available online, for example a learning module for pressure ulcer prevention and management.

Multi-disciplinary working and coordinated care pathways

- All the community team nursing and therapy staff attended handover meetings.
- Staff were able to consult with colleagues, for example with specialists in tissue viability, diabetes and continence.
- There was effective multidisciplinary working across teams in the trust. For example the rapid response team had good links with the hospital, community nursing and therapy services. Some staff were based in the same office as community nursing and therapy staff.
- There was also close work with external professionals such as social services and GPs.

Referral, transfer, discharge and transition

- Referrals to the community nursing services were made via a single point of access. This was provided by nursing and therapy staff from community teams who worked on a rota basis. The single point of access operated for twelve hours a day, 7 days a week. Referrals came via a GP, other professionals and patients could self-refer.
- Referrals were triaged and prioritised according to needs.
- Rapid response services were available for patient's experiencing a health crisis or to prevent admission to hospital. For example, falls without injury, unstable diabetes, patients with urinary tract infections or exacerbations of chronic obstructive pulmonary disease or congestive heart failure. Services were initiated within two hours of referral and staff worked closely with the patients GP, district nurses and other health, social care and voluntary services to identify the most appropriate package of care.
- There were dressing clinics run by community generalist nurses. These were for patients being discharged from hospital or referred by their general practitioner, district nurse, or other health professionals, following surgery or a medical procedure that will require aftercare.

Good

Are services effective?

- The teams saw patients for varying lengths of time, up to three times a day depending on their individual needs.

Access to information

- An information folder was given to new patients. This contained various leaflets and included information on the service and how to complain.
- Information was also available on the trusts website, but some of this was being updated at the time of the inspection.
- Information on trust policies and procedures was available on the trust intranet. This meant that staff could access advice and guidance easily.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Training on the Mental Capacity Act was not mandatory, although the trust had plans to put this into place.
- Staff explained procedures for gaining consent from patients before providing care and treatment. Staff were confident about seeking consent from patients but less confident about what do if the patient potentially lacked capacity. Nursing and therapy staff in the community teams and specialist services showed awareness of the need for mental capacity assessments to take place but said they would discuss this with their manager, other clinicians such as the GP for advice.

Good

Are services caring?

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

Summary

We rated caring as **good** because**:**

- Patients received a caring service from staff that were kind and respectful toward them.
- Nursing and therapy staff treated patients with dignity and involved patients and their families in discussion about their care.
- We found that staff had considered the patients' emotional needs.

Compassionate care

- The patients we spoke with were very happy with the care they received.
- We observed reception staff in clinics assisted patients promptly and they were caring, friendly and efficient.
- The nursing staff were observed taking telephone calls and receiving referrals from patients and professionals. They responded in a polite and caring manner. Staff were patient and did not hurry patients ensuring they understood what the problem was so they could pass on referral to the most appropriate person.
- Staff were greeting patients in a friendly, but appropriate manner. One patient told us staff were very good and had responded quickly when they rang.

Understanding and involvement of patients and those close to them

- We saw some staff took time to ensure that patients understood their care and treatment and were involved in making decisions. However, there were limited records showing how patients and their relatives had been included in the assessments and ongoing care decisions.
- One member of staff gave us an example where they had identified the patient who needed additional support from an interpreter to enable them to be involved in their treatment, however most nursing staff said they rarely used interpreter services and used other family members as a resource instead.
- Written information was available to patients about their care and treatment and medical conditions.
- Patients were able to raise concerns and comments when they had their initial assessment meeting. Patients seen by the rapid response service had a holistic assessment completed on their first visit.
- Staff supported patients to manage their own health care and maximise their independence. For example by the use of telehealth services.

Emotional support

- During our visit we observed community nurses providing emotional support to people and their relatives in their own homes. Staff listened to what patients said and responded appropriately. One patient said they had nursing staff visiting them for over a year and most staff 'listened' to what they wanted and understood their needs.
- Staff in handover meetings demonstrated knowledge, skill and a caring attitude towards patients during their discussions.
- Therapy staff encouraged patients to manage their own health needs to maximise their independence by offering bespoke advice and information on additional support networks to manage their health condition.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as **good** because:

- The trust worked with commissioners, local authorities, people who use services, primary care services and other local providers to ensure it understood the needs of its population in order to plan and deliver services.
- The services provided a range of specialist interventions to meet the different needs of patients.
- Most services were delivered in a timely manner, especially where the care was more urgent.
- The trust was aware of the diverse needs of the people who used the service and they provided a range of support as required.
- Staff considered the needs of people who may have difficulty accessing services and adapted their care approach to show respect for cultural factors.
- There was evidence of learning from the complaints received from patients and families.

However:

- Wheelchair services were not always delivered in a timely manner. This was acknowledged by the trust on the directorate risk register with actions in place.
- Patients were offered a morning or afternoon appointment slot by the district nurses but would have preferred more information about the time of their appointment.

Planning and delivering services which meet people's needs

- The extended primary care team offered a range of services dedicated to treating patients' needs that included prevention of admission and supported discharge services They were able to provide a range of different treatments and therapeutic interventions including rehabilitation therapies and intensive home support.
- The trust worked closely with commissioners, local authorities, people who used services, primary care services and other local providers to ensure it understood the needs of the population it served in order to plan and deliver services. For example, a decision had been made by commissioners to close the virtual ward service and patients were being transferred to the rapid response service. The virtual ward service had provided patients with support over a longer timeframe than the rapid response service however the lead manager told us they were currently in the process of reviewing the criteria and timeframes for involvement from rapid response services. All patients would continue to receive the services they needed for as long as was needed. Staff from the virtual ward service were being transferred to rapid response where posts were available.
- The diabetes specialist nurse team provided support in diabetes management for people with diabetes, who were newly diagnosed or who required more specialist advice, intervention and support. The team worked across the borough supporting adult services as well as young adults / adolescents (16-25) and children (0-16). The team were nurse prescribers who were able to quickly initiate diabetes treatment and management.
- The trust provided specialist nurse led continence assessments, investigations, treatment and support to people who had bladder, bowel or pelvic floor dysfunction. People were seen in clinics, their own homes, local hospital and day-care facilities. The service also managed the provision of continence products for people living in the community and residential homes in the borough of Newham.

Equality and diversity

- Staff and managers had undertaken equality and diversity training as part of their mandatory training.
- The trust had a commitment to ensuring a positive culture relating to equality, diversity and inclusion throughout the organisation. Throughout community services we found that people's diversity needs and human rights were respected.
- Staff we spoke with were able to give us examples to demonstrate their understanding of equality and diversity.
- Patient information and leaflets could be provided in large print for people with visual impairment or in easy read versions.

Good

Are services responsive to people's needs?

- The trust had arrangements in place for telephone interpreting and face-to-face interpreting. Patients that required written information in languages other than English could contact the patient advice and liaison service help centre for advice.

Meeting the needs of people in vulnerable circumstance

- Staff were aware of the communication needs of patients with dementia. Dementia awareness training was available for staff to access.
- Staff demonstrated an awareness of the needs of patients with a learning disability. One nurse said they would liaise with the patient's family and any professionals involved ensuring they communicated appropriately.

Access to the right care at the right time

- The rapid response team, completed a comprehensive holistic assessment of all referred patients within 2 hours and then could refer on to the appropriate community and social services, liaise with referrer and patients GP. The team provided 24 hour cover and could be contacted via the single point of contact.
- The district nursing service was available from 8am to 10pm. There was no commissioned district night nurse service. If patients needed help after 10 pm they needed to ring 111 or go to accident and emergency.
- Patients were allocated morning or afternoon slots and staff endeavoured to arrive within those timeframes. Feedback from patients we spoke with was that they always got a visit but were frustrated that they never knew what time the nurse would arrive.
- Managers told us the district nursing service was currently reviewing its referral criteria and there were no written referral protocol for staff to follow. Nursing leads were clear that patients should be housebound and require a nurse to visit to be accepted for the service. Staff and managers told us they knew they had patients receiving home visits that did not meet these criteria and there were plans to set clear criteria for triage staff to follow in the near future. This would ensure staff resources were targeted on those patients most in need.
- People who did not have a permanent GP and experienced difficulties in registering locally with a GP could access the Newham transitional practice, which was available across two locations. Patients could be seen at either site wherever appointments were available. A new entrants screening service for new arrivals to the UK, and a homeless service for people without a permanent residence was also available.
- The wheelchair service had long delays for assessment and provision of a wheelchair. Therapy staff told us the waiting list was 16-18 weeks. For example one patient with complex care needs had been waiting three months for a new wheelchair. During that time they had been unable to go out as lived in a high rise flat. The trust had recognised problems with the wheelchair service and performance data confirmed lengthy delays. It was however recognised that this sometimes related to waiting for orders for specialist equipment to arrive. The delays were on the directorate risk register with actions in place to improve the responsiveness of the service.
- Foot health clinics clinic were provided at three locations including East Ham Care centre. We observed staff providing foot health are to three patients. Patients we spoke with in the clinic were generally happy with their care although the majority complained about the time taken to get their appointment. Staff told us they did not have enough staff but the trust were aware and were in the process of recruiting. this meant non-urgent patients had to wait longer than they would have liked. All patients were seen within the referral to treatment target timeframe of 18 weeks.
- For the diabetes service urgent referrals were seen in clinic within two days, non–urgent within 18 weeks. Annual performance data for April 2015 to March 2016 confirmed that patients were seen within timeframe of 18 weeks.
- Transport for clinics could be booked for patients who met criteria.
- Staff and patients told us that there were no delays in getting pressure relieving equipment delivered and they had no problems in getting this equipment when they needed it.

Learning from complaints and concerns

- Community adult services received 76 complaints between January and December 2015. Of these, 22 were upheld, 16 partially upheld and five were still being

Good

Are services responsive to people's needs?

investigated. The most common themes were communication, appointment delays and cancellation and attitude of staff. Staff received 23 compliments during the same period.

- The trust had 'you said we did' boards which informed staff and patients about what was being done in response to feedback from patients. For example in the foot health clinic, patients had commented on a long time for appointments and so two additional staff were being recruited.
- Patients we spoke with said they knew how to make a complaint. The patient advice and liaison service information booklet was available from the trust website and was available in a range of local community languages.
- Patients could complain to the patient advice and liaison service if they were unable to resolve the issue locally.
- Staff told us they received feedback and shared lessons learnt from complaints if they were about themselves or the team. Those teams that had regular team meeting's said complaints were sometimes discussed and any changes that needed to be made.

Good

Are services well-led?

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

Summary

We rated well led as **good** because:

- Staff were mostly positive about senior leadership and said generally leaders encouraged and supported staff so they felt respected valued and supported.
- The culture in the service was open and staff felt able to raise concerns.
- Staff engagement had been promoted through a programme of six team away days.

However:

- Team meetings were not always happening regularly for all staff.

Service vision and strategy

- Managers had a clear vision for their service with a goal of integrating services as much as was practical to ensure a seamless service for patients. They highlighted the challenges of the impact continuous changes had had on staff and the need to become more efficient at targeting services to those most in need.
- Most staff told us they felt part of the trust. One staff member said board members visited teams and one had gone out on visits with nurses.
- Staff explained the trust vision and all were positive about working for the trust. Most managers were aware of the trust values however this was not so well known amongst frontline staff.

Governance, risk management and quality measurement

- Governance structures were in place across the trust. The adult community services were part of the directorate for Community Health Newham and Mental healthcare of Older People Directorate. This had two clinical directors and a service lead. There was a monthly directorate management team meeting, for senior staff to review management and quality information.
- Community services provided monthly performance reports showing agreed performance targets for access to services for patients with urgent and routine needs against the service level agreements.
- Quarterly quality and performance review meetings were held with the trust executive team. This meeting reviewed quality and performance issues at a strategic level.
- The team meetings incorporated governance discussions such as learning from incidents and complaints. Some meetings especially for district nurses were not always happening regularly and information was not shared consistently.

Leadership of this service

- In all of the teams we visited we found that most staff felt proud of working for the trust and were positive about their work. Managers told us about the challenges they experienced with recent restructuring in community services and further challenges and restructuring that was planned. They were clear about the need to support the trust to improve the quality of community adult services.
- Local leadership was praised by staff as visible, accessible and responsive.
- Staff morale within the trust was mostly positive and most staff felt they were listened to and supported. Some staff said they had not been listened too as changes were made that then had to changed again as they did not work. This meant some staff had left and others were in the process of leaving in community nursing and therapy services.

Culture within this service

- Staff shared their views about the service openly and constructively. They were caring and passionate about the service and the care they provided to patients. Staff felt they worked well together as a team and staff morale was high

Good

Are services well-led?

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

Staff engagement

- The national staff survey score analysed for each directorate in the trust, showed that staff working in this directorate had high scores for engagement. For example 71% of staff reported that communication with senior management was effective.
- The staff friends and family test said that 71% of staff would recommend the trust as a place to work which was 9% above the England average of 62%. However 1.7% of the number of staff completed the survey.
- The trust had procedures in place for staff to raise 'whistleblowing' concerns outside of their line management arrangements.
- The trust regularly sent out a newsletter to staff and staff were encouraged to look at the staff intranet.
- In 2015 a programme of staff engagement called 'keep it together days' had been delivered on six occassions to the community teams in two locality bases, the East Ham Care Centre and Vicarage Lane. The purpose was to build staff morale and a culture of team working, listen to staff and help them feel valued and improve communication and quality of services.

Innovation, improvement and sustainability

- There was a commitment to continuous improvement and an example of this was the work that had been done to reduce the number of patients acquiring pressure ulcers whilst in receipt of a service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes must be established and operated effectively to ensure compliance with the Health and Social Care Act 2014 The records in respect of each patient were not accurate and complete and so it was not possible to ensure they had been thoroughly assessed and had appropriate care and treatment plans in place that were being carried out in a timely manner. This was a breach of regulation 17(1)(2)(a)(b)(c)