St George's Healthcare NHS Trust

Quality Report

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Date of publication: 24/04/2014
Date of inspection visit: 10-13 February 2014

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information we hold about quality, and information given to us from patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

St John's Therapy Centre is a registered location for St George's Healthcare NHS Trust community services. Since 2010 the trust has provided a range of community services within the London Borough of Wandsworth from Bridge Lane Health Centre, Doddington Health Centre, Eileen Lecky Clinic, Stormont Health Centre, Tudor Lodge Health Centre, Brocklebank Health Centre, Westmoor Community Clinic, Balham Health Centre, Joan Bicknell Centre and Tooting Health Centre as well as St John's Therapy Centre. The trust serves a population of approximately 1.3 million across South West London and provides services for older people, adults with long-term conditions, people with learning disabilities, families and children.

Continuing care

Community services aim to provide a service for adults over the age of 16 years with physical health needs, including:

- Diabetes specialist nursing
- Heart failure specialist nursing
- Integrated falls and bone health service
- Intermediate care
- Nutrition and dietetics
- Occupational therapy
- Podiatry (including podiatric surgery)
- Respiratory specialist nursing
- Speech and language therapy
- Tissue viability specialist nursing
- Hemoglobinopathies
- Neuro-rehabilitation
- Wandsworth integrated community equipment service

The service is designed to promote healthier lifestyles, physical, psychological and social wellbeing, and supports and encourages people with disability and long-term conditions to live independent lives. Services work with other healthcare professionals (such as GPs, continence service, Macmillan cancer support team, practice nurses, therapy services, tissue viability nurses) to deliver comprehensive and effective care to clients. Specialist services are available for people with diabetes, epilepsy, neurological conditions, physical ailments, cardiac conditions, and so on.

The trust also has four community wards within the London Borough of Wandsworth. Each of the four wards support current systems and have a GP, social worker, pharmacist, ward clerk and advanced nurse practitioners. Other key staff include community matrons, community (district) nurses and healthcare support workers and therapists. One ward has a mental health nurse on a pilot basis. The four community wards are – Central Wandsworth (Wandle), North Wandsworth (Battersea), West Wandsworth (Roehampton/Putney) and South Wandsworth (Balham/Tooting/Furzedown). The aim of these wards is to proactively manage patients in the community with long-term/chronic conditions to reduce the number of unplanned admissions to secondary care. They provide a rapid response to urgent requests for community services to enable patients to be managed in an acute phase at home, thus avoiding admission to hospital. They are also able to provide assistance in the safe, early discharge of patients from secondary care back into the community.

Community learning disability

The Wandsworth community learning disability team is a specialist multidisciplinary team offering a community service to adults over the age of 18 with a learning disability living in the London Borough of Wandsworth. The overall aim is to improve the physical and mental health and wellbeing for service users. The multidisciplinary team comprises community nursing, dietetics, dysphagia service, occupational therapy, physiotherapy, psychology and speech and language therapy, supported by an administration service and an access and referral management service. They work in close collaboration with learning disability social workers.

The community learning disability team offers a range of assessments and interventions for:

- Communication
- Challenging needs
- Coordination and facilitation of health needs
- Dysphagia (swallowing difficulties)
- Mobility/exercise/postural management
- Physical health issues
- Activities of daily living (such as dressing and bathing)
- Support in hospital/medical appointments

Summary of findings

- Significant emotional and relationship difficulties.

Family and children's services

Services are provided from a number of clinics and include well-baby checks, as well as family planning and Sure Start programmes. The services are well integrated into the local authority and include:

- Health visiting services
- School nursing
- Midwifery clinics
- Children's continuing care
- Sexual health
- Children's therapies
- Childhood immunisation
- Child health records
- Homeless, refugee and asylum-seekers service
- Special schools nursing
- Children's speech and language therapy.

This is the first inspection of St George's Community Services. Overall, we found that St George's Community Services were meeting the core questions.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

People received safe care and were protected from abuse, avoidable harm and risks. Risks were assessed and regularly reviewed so that people's individual needs could be met safely. Safeguarding children and adult processes and procedures were known to all staff who were confident to report serious incidents, areas of concern and poor practice. There were good safety checks within the assessment processes and staff were able to learn from safety incidents such as falls, medication errors and pressure ulcers.

Are services effective?

People received effective care from staff who were specially trained and supported. National guidance and evidence-based practice was being implemented across the services. Staff spoke confidently about evidence-based practice and about the service meeting national targets. We saw excellent examples of multidisciplinary working with statutory and external agencies to meet the needs of children and families. Appropriately skilled, qualified and knowledgeable staff were available to meet patients' needs.

Are services caring?

Services were good and caring. This was confirmed via feedback from families using the service, surveys and our observations of care. Staff respected peoples' privacy, dignity and their right to be involved in decisions and make choices about their care and treatment. People told us that staff were caring and compassionate. We saw excellent examples of care being provided with compassion as well as effective interactions between staff and patients. Staff spoke with passion about their work and were proud of what they did.

Are services responsive to people's needs?

We saw that the service responded to the needs of the local population and that systems were in place to ensure learning from information gathered from the experiences, both positive and negative, of patients receiving care and treatment. People from all communities could access services and effective multidisciplinary team working, including liaison between community-based teams and other health and social care professionals was in place. This ensured people were provided with care that met their needs, at the right time and without delay. The staff had a clear awareness of existing and emerging issues within the local areas, and responded proactively to changing local priorities. Information for the public was available in English but not in always in a format that all people could understand.

Are services well-led?

Services were well-led. Governance arrangements were in place and staff were clear about the values of the trust. The service is focused on making sure it provides good quality and safe services. Staff said they were well supported by their local managers but felt that senior management were not visible in the community services and that the organisation was focused on the acute services. Concerns were raised in relation to the IT systems used in the community as they were not all the same, meaning there were problems linking to each other and the acute services. Staff generally felt well supported to raise concerns. Many staff told us that it was a good place to work.

While the majority of staff had received mandatory training, the level of clinical supervision afforded to staff was not being adequately monitored or rolled out to all staff.

Summary of findings

What we found about each of the core services provided from this location

Community services for children and families

We found the service provided by St George's Healthcare NHS Trust, community health services for children, young people and families was good.

The safety of children and families was promoted through the proactive approach of the community teams and the staff having a clear understanding of their responsibilities in relation to safeguarding and child protection. There were good systems for ensuring that risks were responded to through partnership working with other agencies in order to protect children and ensure that concerns were dealt with through a multidisciplinary approach. Learning from incidents took place and actions were implemented to improve practice and the safety of the children and families.

The services were effective in working with partner agencies in the long-term care of children and families to ensure that children received the care and support they needed near to their home. The health centres were located throughout the borough and provided clinics at different times to allow people to access services at a time that suited them. Staff were supported in their work and followed best practice guidance. However, information relating to staff training was inconsistent and did not give an accurate record of the training received. Some staff within the family planning services were not aware of their responsibilities within the Mental Capacity Act 2005.

The children and families services were caring and people were involved in identifying their needs and the support they required from the service. People were treated with dignity and respect, and we observed that professionals confirmed people's understanding of treatments offered and any risks involved. All staff conveyed a clear understanding of supporting the whole person, and taking into account their emotional and social situations, as well as physical and medical needs.

Specialist services had been developed in response to the needs of the local population, and to emerging needs that were specific to the area. Services across the health centres were accessible to all people living within Wandsworth, with efforts made to promote the services to specific groups that did not make use of the services available, or did not attend appointments. However, the trust did not routinely monitor the diversity of people who used the community services, and information in other formats or languages was not always available for people to access.

The children and families' services were well-led. The governance arrangements of the trust ensured that monitoring of the community services took place. There were clear management structures in the community services and staff felt well supported by their local line management. However, the majority of staff we spoke with felt detached from the trust and that there was a lack of senior management presence in the community services. Similarly, the IT systems in use across the community services did not link up with to each other, which meant that important information about children and families could be missed. This did not impact on patients care but was frustrating for staff.

Community services for adults with long-term conditions

Overall, we found that services provided to adults with long-term conditions were safe, effective, caring, responsive and well-led at a local level.

Staff were aware of adult protection and safeguarding. Staff reported serious incidents or concerns and the trust had good systems and processes in place for recording these. There was less clarity on how learning from safeguarding, incident reporting and complaints was disseminated down to an individual community team level. Processes for communicating with the clinical team leader level were in place.

Summary of findings

The delivery of care and treatment was based on guidance issued by appropriate professional and expert bodies and a number of care pathways were in use. We saw that staff were involved in monitoring and assessing the quality of care, including the development of guidelines and protocols. We saw and heard evidence of innovation and a proactive approach to performance improvement at local level.

Staff demonstrated a caring approach. Patients and relatives spoke highly of the care they had received. We saw staff delivering care that was compassionate, planned according to people's individual needs, and which focused on encouraging patients to maintain their independence.

We found the service was responsive to patients' needs as well as to feedback from patients and relatives. Cascade of learning following review of feedback between teams was not conducted as a matter of routine.

The majority of staff understood the requirements of the Mental Capacity Act 2005, although there was little evidence of recently updated training. Staff were able to demonstrate an understanding of the care needs of a person living with dementia. Dementia training was not included in the provider's mandatory training programme and we could find evidence of very few community staff having received such training.

The services provided to patients with long-term conditions are well-led at a local level, although escalation and reporting of risk above service level required further development. Staff had clearly defined roles and responsibilities and there was a sufficient skills mix to meet the care needs of people with long-term conditions. There was a mostly open culture locally where staff felt able to raise concerns and know that they would be acted on.

Some staff told us that they felt isolated from the acute hospital, while others felt well integrated. All staff we talked with expressed concerns about the lack of an integrated IT system and prompt support for IT issues in the community. While this did not impact on the care patients received it was frustrating for staff.

Summary of findings

What people who use the community health services say

All of the people we spoke with during the inspection said that they were satisfied with the services and happy with the care they received. Some commented on the "excellent support" from the nurses which enabled them to stay at home.

The trust's patient issues committee of 27 February 2013 reports on the first coordinated annual patient survey programme. During a two-week time frame in November 2012, all community services undertook a patient survey. Thirty-seven services provided sets of results and 2,813 surveys were completed overall. The average score for each question was over 80%. However, we were not provided with the detailed results for community services for adults with long-term conditions.

The patient issues committee of 5 February 2014 reports that a community services annual patient survey was carried out from 7–14 November 2013. The data analysis is not yet completed. Initial findings show 2,218 responses and an overall average score of 89%. The final results are due later in February 2014.

People commented on the fact that the community children's nursing team were "fantastic" and that they had taken the time to "understand their specific needs". They were also very happy that the nurses were teaching them how to provide care for their children at home.

Areas for improvement

Action the community health service SHOULD take to improve

- Defibrillators and resuscitation equipment should be reviewed in all premises where coil fittings and implants are performed.
- Information should be reviewed to address the communication needs of the local population.
- All clinical staff should receive safeguarding supervision from a named professional, in line with best practice guidance.
- The trust should review the integration of the IT system and ensure a prompt response to community IT issues.
- Senior managers should be more visible in the community settings to enhance leadership.
- We found that some staff did not feel a sense of belonging within the trust and that communications and some training was 'acute focused' and not relevant to community staff.

Good practice

Areas where we found good practice include:

- Excellent multidisciplinary working across the community services.
- Staff were committed to promoting communication and patient-centred planned care and worked hard to build the required relationships both internally and externally.
- Staff focused on the individual patient and worked hard to build trusting and open relationships with patients.
- Staff said they felt able to raise any concerns about their work with the line manager and that they were confident this was acted on. The safety of children, young people and families was promoted through the specific systems developed by the trust.
- The service was responsive to the needs of the local population. The staff had a clear awareness of existing and emerging issues within the local areas, and responded proactively to changing local priorities.

St George's Healthcare NHS Trust

Detailed Findings

Services we looked at:
Community services for children and families and Community services for adults with long-term conditions

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Director of Quality & Commissioning (Medical & Dental), Health Education England

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission (CQC)

The inspections team was made up of 10 people, including CQC inspectors and a variety of specialists, including experts by experience, nurses and doctors.

Background to St George's Healthcare NHS Trust

St George's Healthcare NHS Trust took over the management and running of the Wandsworth Borough Community Services in 2010. Although St John's Therapy Centre is the registered location for these services, community services are provided across the London Borough of Wandsworth from Bridge Lane Health Centre, Doddington Health Centre, Eileen Lecky Clinic, Stormont Health Centre, Tudor Lodge Health Centre, Brocklebank Health Centre, Westmoor Community Clinic, Balham Health Centre, Joan Bicknell Centre and Tooting Health Centre as well as St John's Therapy Centre. .

They also provide services for Wandsworth Prison and in GP surgeries, schools, nurseries and community centres, as well as patients' own homes.

Why we carried out this inspection

We inspected this hospital as part of our indepth hospital inspection programme. We chose this hospital because it was considered to be a lower-risk service.

How we carried out this inspection

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

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

Detailed Findings

The inspection team always inspects the following core services at each community inspection:

- Community services for children and families
- Community services for adults with long-term conditions

Before visiting, we reviewed a range of information we hold about the therapy centre and the trust and asked other organisations to share what they knew about the service. We carried out an announced visit between 10 to 13 February 2014. During the visit we held focus groups with a range of staff working in the centre, nurses, doctors, physiotherapists, occupational therapists and pharmacists. We talked with patients and staff from all areas where services were carried out. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the location.

Community services for children and families

Information about the service

The children and families community services provided by St George's Healthcare NHS Trust include care services provided by health visitors, midwives, school nurses, community nurses, specialist children's nurses, speech and language therapists, physiotherapists and consultant paediatricians.

The inspection team included two compliance inspectors, a health visitor, registered children's nurse, school nurse and an expert by experience. During our inspection we spoke with around 60 staff and 20 children and parents of children who use the service. We also spent time in the children's outpatients department, where we asked people to complete comment cards about the service they received. We received eight completed comment cards.

We visited a number of health settings that provided services to children and their families. This included Tooting, Balham, Stormont and Brocklebank health centres and St John's Therapy Centre. We also visited the children's outpatients department based in Queen Mary's Hospital. We attended four home visits with two health visitors and observed a number of individual therapy sessions with children and their parents. We facilitated a focus group with some school nurses, health visitors, speech and language therapists and physiotherapists. We also used information we requested from the organisation.

Summary of findings

We found the overall service provided by the children and families community services of St George's Healthcare NHS Trust was good.

The safety of children, young people and families was promoted through specific systems developed by the trust. Any identified risks to the welfare of children and their families were assessed and plans put in place to minimise these. Risks were regularly reviewed so that people's individual needs could be met safely. Staff we spoke with were clear about their accountability and responsibilities in safeguarding children.

The effectiveness of services was good. The staff received training and support for their work with children and families to ensure they provided effective care. We found examples of national guidance and evidence-based practice being implemented across the services, and staff spoke confidently about this and meeting national targets. There was clear evidence of working with statutory and external agencies to meet the needs of the children and families.

Services for children and families were caring. The feedback we received from children and families was that they valued the services they received and were happy with the treatment and care provided. Parents said they felt listened to and involved in the treatment plans for their child and said that staff explained things in a way they could understand. They said they were treated with respect and given advice and information in relation to looking after their children. All parents we spoke with said they would talk to staff if they had any worries or concerns.

We saw that the service was responsive to the needs of the local population. The staff had a clear awareness of existing and emerging issues within the local areas, and responded proactively to changing local priorities. We found that information was not always available in different formats or helpful to those whose first language was not English.

The children and families service was well-led. Information provided by the trust showed that monitoring of the quality of these services took place and where necessary remedial action taken. Staff in

community services felt supported by managers at service level, though not supported by more senior managers. The majority of staff felt detached from the acute services and felt that the community services were not connected to the trust.

Are community services for children and families safe?

(for example, treatment is effective)

Safety in the past

The safety of children, young people and families was promoted through the systems developed by the trust to safeguard children and their families. Parents told us that they felt confident of the competence of all the staff and they were assured their child received appropriate care to meet their needs. All teams had an early intervention, proactive approach that supported families where they were having difficulties. The staff we spoke with were clear about their responsibilities in safeguarding children and gave us clear examples where concerns had been identified and acted on. These were in relation to the safeguarding of the child or their parent, such as in domestic violence situations.

The electronic care records we viewed showed that all children and young people with a child protection plan or any other identified risks had an alert against their name. We were shown examples of child protection/safeguarding care plans and evidence of their regular review to ensure that risks were being managed effectively and that work was in progress to achieve the agreed outcomes.

Staff were able to demonstrate that they had formed links with other agencies such as health, education, social services and the police through attending chid protection case conferences. They also promoted a holistic approach to protecting children from abuse.

Staff told us that they had access to a safeguarding lead nurse for support and advice; they had clinical supervision with this nurse every three months; they could also seek telephone advice from the lead nurse if required. The records of staff meetings also showed that supervision was a standing agenda item for discussion. The staff told us that they received safeguarding training at the level appropriate to their role. The training records showed that staff had received safeguarding children training up to level 2, staff across the community services had received training at level 3 where appropriate. Clinical staff told us they received safeguarding supervision. However, in most cases we found that this was delivered by their direct line manager and not an independent safeguarding supervisor

or named professional, as is best practice (Safeguarding Children and Young people: roles and competences for healthcare staff, Intercollegiate document September 2010, Royal College of Paediatrics and Child Health).

Learning and improvement

Staff in the different settings told us how incidents that had occurred, and the findings of serious case reviews had made them reflect on and improve their practice, such as improving communication between professionals and identifying a lead professional to oversee people's care and support. Similarly, we were shown improvements that had been made to the systems for monitoring follow-up appointments, especially where families did not attend.

The community services used the Datix software system to report any incidents, so that data could be captured and monitored by the trust. We were shown examples of reports that staff had completed and any new actions that had been implemented as a result of an incident. For example, improved record-keeping around contact with families and working with partner agencies to ensure accurate information was held. The trust also used complaints to drive improvements and understanding through videoing complainants telling their stories. Where complainants were not happy to do this actors were used.

Systems, processes and practices

There were appropriate safeguarding policies and procedures in place and these were easily accessible to staff. For example, all policies and procedures including incident forms were available to all staff on the intranet, along with statutory guidance relating to safeguarding children.

There was a lone working policy for community services that had been kept under review by the trust. The community staff told us how they assessed their own personal safety prior to visiting people in their homes. They said that, if a risk had been identified, they were accompanied by another health visitor or worked with a social worker involved with the family.

The majority of staff told us that their line managers were supportive and there was effective teamwork. Staff said they felt able to raise any concerns about their work with the line manager and that this was acted on. For example, where staff had reported that they were at risk, their line manager had put in additional support to ensure that their safety was maintained.

There were systems in place to minimise infection risks to children and families. Within the children's therapies services, there were local guidelines for cleaning and hygiene, as well as records of cleaning schedules. These records showed there was periodic cleaning of play equipment in the children's outpatient departments. We observed that hand-sanitising equipment was available for use in the baby clinic, and also disposable sheets for the changing mats. However, we did observe that not all staff washed or sanitised their hands between seeing each baby. Also, parents of one baby had to remove the used sheet and replace this with a new one for their baby.

We also found that one of the treatment couches in the family planning service (Tooting Health Centre) was damaged and could not be used. This resulted in appointment delays.

Monitoring safety and responding to risk

Any identified risks to the welfare of children and their families were assessed and plans put in place to minimise these. Risks were regularly reviewed so that people's individual needs could be met safely. Records we viewed detailed individual risks to people and how these were to be managed. We saw evidence of risk and intervention plans in place to safeguard people. Examples we viewed included a mood assessment for new mothers, work with parents where substance misuse was an issue and working with fathers where a risk had been identified. The mental health needs of the families under the continuing care team were also supported through the involvement of a dedicated mental health nurse who worked with families and children to support them through diagnosis and living with chronic conditions through their childhood and adolescence.

Within the health visitor teams we saw that team meetings took place to review caseloads to ensure that risks were identified and prioritised. Staff told us that, during these times, each health visitor's work was reviewed in relation to the level of risk within individual caseloads, and evenly distributed to ensure that risks were addressed.

Health visitor teams had a duty system, whereby all referrals were triaged to prioritise patients and allow risks to be responded to in a timely manner. Examples we were shown included a child in the accident and emergency department with a serious injury, and where increased risks

were identified where children were already subject to child protection plans. Staff also told us about the actions they took where families were known to service providers but did not engage with interventions.

At Tooting Health Centre, there was no defibrillator or resuscitation equipment on the premises. This was a potential risk as the service provided coil fittings and implants to women, and these fittings can cause a reaction that may require an immediate emergency response. Staff we spoke with said they would contact the emergency services if this occurred.

Anticipation and planning

The divisional director of nursing, trust chairman and operations manager stated that they were aware of some staffing concerns, especially for the future, and had held a large drive to secure staff from other countries such as Spain, Portugal, and Ireland as well as Scotland. This recruitment drive had been successful and staff were in the various stages of the recruitment process. They had a clear business plan in place to meet the ongoing needs of the service.

Are community services for children and families effective?

Evidence-based guidance

The records we viewed demonstrated that the community services were complying with best practice in their services. For example, breastfeeding rates, visits to new-born babies in their family setting and developmental reviews on children younger than 3 years old.

The staff we spoke with told us about how they planned their work to ensure that the service met national guidelines and standards in relation to child health. This included the implementation of best practice initiatives such as Maternal Early Childhood Sustained Home-visiting (MECSH) and Healthy Child Programme. This ensured that children who were in need of additional support were identified so they could be helped appropriately.

Staff within the continuing care service told us about work they did with young people regarding their transition from children's to adult services, and how they ensured that this followed best practice guidance, in accordance with the national framework for NHS continuing healthcare and NHS-funded nursing care (November 2012, revised).

The health visitors showed us how they followed the National Institute for Health and Care Excellence (NICE) guidance to ensure that the mood assessments they carried out on new mothers took place within four to six weeks following birth. Health visitor managers showed us how they monitored this monthly to ensure that these were carried out within the timescale. Similarly, within the speech and language therapy services, the therapists gave us information about the Every Child a Talker: guidance for early language lead practitioners (Department for Children, Schools and Families, 2011) national strategy that they used evidence from to improve the service provided to children and families, with a specific drive to get children talking at an early age.

We spoke with staff about consent and capacity to consent practices in relation to legal requirements. Staff were aware of the Gillick competencies and Fraser guidelines for deciding whether a child is mature enough to make decisions and give consent and how this impacted on their work with children. Within the health visiting teams, the staff conveyed a clear understanding of their accountabilities within the Mental Capacity Act 2005. However, within the family planning services, the staff we spoke with were less aware of their responsibilities within the Act, and the feedback staff gave was that capacity assessments were the duty of the doctor only. The training records showed that staff had not received training in the Mental Capacity Act 2005.

All the staff we spoke with were aware of national best practice guidance and initiatives, such as NICE guidelines and Department for Children, Schools and Families guidance. Similarly, staff were aware of targets in relation to the government's Healthy Child Programme and the need for regular developmental reviews of babies and young children.

Monitoring and improvement of outcomes

We were provided with some evidence in relation to the governance arrangements of the trust in monitoring the services provided to children and families in the community.

We were shown the dashboard (performance reporting and tracking system) that service-level managers completed monthly to ensure regular and timely information about the effectiveness of children and families services was provided to the trust. For example, within the health visiting and family planning services, we saw that the

performance and delivery of the service was recorded on a scorecard to enable senior managers to assess and monitor the effectiveness of the services delivered. Regular quality reviews took place with the management team and findings were reported through the trust governance structure. The divisional leads regularly reviewed the information and ensured that national targets were being achieved or actions put in place if there were any concerns.

These monitoring systems showed that the trust and senior managers were kept informed of quality issues, risk and key performance indicators in relation to each of the services provided under the children and family's community services.

Staffing arrangements

We spoke with staff across all the sites we visited and they were enthusiastic and showed commitment to their work. The staff said they generally felt well supported and able to contact any member of staff for advice if they were unsure about something. They said they received regular support through individual meetings with their manager, and through regular team meetings. We saw evidence that staff received regular supervision and appraisals that considered their personal and professional development. Staff told us that they had been supported to gain further qualifications that enabled them to progress and develop skills to enable them to effectively meet children's needs. However, information provided by the trust showed that staff appraisal up until December 2013 had not met their target of 85% across the community services.

We spoke with some staff who had been recently employed by the trust, who told us that they received an induction to working at the service. They also spoke about their preceptorship programme of practical experience and training to support them with their transition from student to professional, and they felt this helped them develop confidence and competence in their practice. We were also shown information about 'action learning sets' that targeted specific training at newly qualified staff, and covered areas such as team dynamics, becoming a leader and safeguarding.

Staff told us that they were contacted by email if they required an update on mandatory training. The trust had a database which recorded all staff training. However, we found that this information did not match that held at service level. The differences in information held about training was also confirmed by the staff we spoke with.

Similarly, there were no records relating to the induction or training that locum/bank (overtime) staff had received, and some professional groups told us that they devised their own training to ensure that bank staff were inducted to their area of work. The divisional leads stated that the induction process for the use of locum/bank staff was continuously under review and improvements made.

Multidisciplinary working and support

We received feedback from families of children with continuing care needs, who required the input of multiple health disciplines. They told us that the service they received was well-coordinated, with a single point of contact.

Staff said that there was generally good multidisciplinary working across all disciplines of staff. However, some did feel that links with external teams, such as Child and Adolescent Mental Health Services (CAMHS) and local authority safeguarding teams could be improved to ensure a more seamless and timely service for people. In particular, staff in all areas expressed concern about the 'threshold' (level at which action was taken) of local authorities for taking on child safeguarding concerns, and the time taken for children to be seen following a referral to the CAMHS service.

There was evidence of different staff disciplines working together across the organisation, such as the paediatric liaison health visitor and community midwife who worked within the acute services, and liaised with community teams around issues such as safeguarding. Furthermore, there was evidence of working with external agencies, such as housing departments and support groups for the specific needs of children, such as those on the autistic spectrum disorder, to ensure that optimum care was delivered. During our home visits with the health visitors, we saw that mothers were provided with information regarding reducing the risk of **sudden infant death syndrome.**

Coordination with other providers

We saw evidence that staff worked collaboratively with partner agencies such as the local authorities, hospitals and commissioners across a wide area, both within the provider's catchment area and outside it. Work took place with external providers, such as voluntary agencies and specialist schools based in the local community, to ensure that children received care and support near to their home. Staff told us about collaborative working with a wide range

of disciplines, such as in relation to safeguarding vulnerable children and family therapy. Staff from the speech and language service told us they had trained 1,000 school staff in strategies for how to help children talk so that they could make the most out of the school curriculum. The service also targeted children who were struggling with speech and language within schools. The therapists we spoke with confirmed that this teaching was now embedded within primary schools in the borough of Wandsworth as this had been identified as a gap in teacher training courses. Individual programmes were in place rather than group programmes which meant that people's individual needs were met and effective relationships were developed with parents and children.

The trust was aware that waiting times from speech therapy triage to receiving treatment were 8-12 weeks. We spoke with staff in the community paediatric outpatients department who highlighted gaps in occupational therapy services for young people with autistic spectrum disorder. The trust is reviewing the provision of the therapies services to address this.

Effective care delivered close to home

The children and families services within Wandsworth were spread across different locations and health centres throughout the borough. Clinics were planned at different times in each health centre, which meant that people were able to access services at a location and time to suit them. The computerised records enabled information about attendance at clinics to be logged and shared among teams to ensure that engagement with services was monitored.

Parents of babies who attended the baby clinics told us that they liked the flexibility of being able to visit a clinic at a time that suited them.

Are community services for children and families caring?

Involvement in care

People we spoke with told us that they were provided with relevant information which helped them to understand the care and treatment choices available to them. Parents of new-born babies told us that they were provided with an information pack and a child health record at the first home visit carried out by the health visitor. They said that the nurses and other professionals always answered their questions and provided reassurance. This included both verbal and written information and advice on breastfeeding, teething, feeding, immunisation and parenting support.

Through observing clinics, attending home visits and talking with parents and their families, we saw that people were involved in their treatment and treated with respect. People told us that they felt involved in the treatment of their child and that their views and concerns about their child's health were listened to and taken into account. Evidence provided by the trust in relation to the continuing care team showed that all care plans were reviewed with individual families to ensure they understood and agreed with the service being provided. Two parents we spoke with told us that their health visitor or the duty health visitor always got back to them if they called the office. One parent said, "my health visitor has known me a long time, she treats me with care and is always there to support me and my family".

Trust and respect

People told us their privacy and dignity were respected by staff. They told us that staff were polite, respectful and treated them with care. We also observed staff during our inspection and the interaction between staff, parents and children. We heard staff reassuring parents and clarifying information. We saw staff providing opportunities for parents and people to ask questions and, where required, people were provided with additional information.

People we spoke with were confident that staff treated them with dignity and respect and protected their confidentiality at all times. It was evident from talking with staff that they were respectful of the children and families they cared for. We observed them using courteous language when describing the children and families they were involved with. We received consistently positive views during the three days of inspection about having choices from a range of people who used children and families community services. These included choices regarding clinics, immunisations and therapies that were available in the borough of Wandsworth.

Some staff described that there were large ethnic minorities within their catchment areas. They told us that they worked with other agencies and the voluntary sector

to ensure that people's needs were met and that individual cultures, beliefs and values were respected. Care records detailed clear information about children's cultural and religious needs.

Patient understanding of their care and treatment

People we spoke with told us they understood their care and treatment. People were provided with information where appropriate, such as information leaflets, contact details and explanations of where there was a need to share contact information. During our home visits we saw good examples of staff checking out people's understanding of their care, such as discussions around breastfeeding, birth weights and diet. We observed a family planning clinic at Tooting Health Centre and saw that people were provided with advice regarding treatments, their side effects and any risks involved.

We saw records relating to discussions with other healthcare professionals and staff told us that they liaised with other professionals in education, social services, voluntary agencies, police and health services to support families. Speech and language therapists and enuresis (bedwetting) nurses demonstrated good evidence of working jointly with parents and children. This included regular reviews of treatment plans, progress and new interventions that were planned.

During the inspection we spoke with 20 people using the service. We received consistently positive views on the children and families service provided. People reported feeling listened to and involved in their care. In relation to surveys, the only results we had referred to the community services as a whole and these showed an overall positive rating of 89%.

Emotional support

Health visitors told us about referrals to Wandsworth psychological service, and where they informed new mothers about a group called 'making the most of motherhood', run by the local mental health hospital. Where women had been identified as being at risk of postnatal depression, regular follow-up visits were arranged. Staff told us the trust promoted an early intervention scheme in this area to achieve better outcomes for women and that vulnerable families were prioritised, for example, if the mother was alone, young, had been subject to domestic violence or there was already a child at risk in the family. Mothers we spoke with told us who their named health visitor was and were able to contact them if they had any concerns or issues they wanted to discuss. All women who had a baby had a maternal mood assessment carried out at six to eight weeks following delivery, in accordance with NICE guidance. This was a universal service that was provided.

The mental health clinical nurse specialist in the specialist school nursing team described the work they undertook with children of all ages, young people and their families. This included working with pupil referral units, referrals from educational welfare, CAMHS and GPs. People within this service could also access family and cognitive behavioural therapy.

All the staff we spoke with were clear on the importance of emotional support needed when there was a new birth, changes in the needs of children and social circumstances for people. Postnatal support groups were provided for first-time parents in the community. The school nursing service also provided support to parents and to children in need. Systems were in place for parents and children to make self-referrals to the service.

Compassion, dignity and empathy

Staff respected people's privacy and dignity. During our inspection we saw examples of staff ensuring consultations took place in private with the door closed. We saw people being treated respectfully and being spoken to about the care they were about to receive.

We received consistently positive views from a breadth of people. This was supported by the views of staff regarding the importance of compassion, dignity and empathy in supporting individuals and their families. The majority of staff spoke with passion about their profession and how their interventions could make a difference. Several professionals described to us their interest in specific conditions, which meant they were able to support parents and children further in a dignified, compassionate manner. This was because they had been trained to do so. For example, within the sickle cell and thalassemia service, staff provided genetic counselling, screening and ongoing support to individuals and families.

Community services for children and families

Are community services for children and families responsive to people's needs? (for example, to feedback?)

Meeting people's needs

In the areas we visited, we found there were numerous, child-friendly information leaflets available to help families. However, information in other formats or languages was not available. We found that the trust routinely monitor the diversity of the people who used the community services, local population needs were accommodated by the service. An example of this was that the community services ran a dedicated sickle cell service in response to the needs of the local population, which included a health promotion and advice service which worked with local schools and provided advice to health visitors and school nurses.

Following a review of the processes and practices around domestic violence, the trust recognised the importance of providing an effective and supportive response to patients and their families exposed to domestic violence. As a result, trust-wide guidance has been produced and plans were in place to employ a domestic violence practitioner to lead on this area within the trust. Staff told us about training they had received in domestic violence, and of strategies they used for working with families. Similarly, staff told us about emerging issues within the local population, such as gang culture, child exploitation and female genital mutilation, and the work that took place with social work teams and the police to respond to these issues.

The community services based at Balham Health Centre provided a specialist service to asylum seekers, refugees and homeless families, such as supporting them to register with a GP to access healthcare services, schools and welfare services.

Within the family planning clinics we found that the clinic times responded to the needs of people in the local area, such as evening clinics and service locations across the borough. The community midwifery team also provided a weekend clinic to families who were unable to see them during the week.

Within the continuing care team the head of the department spoke about the changes taking place within the service to focus on the personalisation agenda and personal budgets. This meant that patients would be able to receive a more personalised service and, where they chose, they could purchase their own care through a personal budget.

Within the sickle cell and thalassemia service (for inherited blood disorders) staff detailed the health promotion work that they carried out throughout the borough so that people were provided with information on the range of treatments and care that were available. The service worked to improve health outcomes for people diagnosed with the condition.

Access to services

There were a number of health centres where people could access midwifery, health visiting, sexual health and family health services at a time and day to suit them. We found that access to therapies, for example, speech and language, across all age groups was well resourced and waiting lists were within national guidelines.

We were provided with examples where staff attempted to improve access to services for children, young people and families. This included specific approaches to following up non-attenders at health visiting clinics, promotion days in local supermarkets by the speech and language therapy team, a Somali fun day run by the homeless team and sending out information to local GP services. Drop-in sessions were available to young people through the secondary school service.

Within the homeless, refugees and asylum services a health advocate was available to support people to access health and social care services. The team also ran regular clinics for people at temporary accommodation hostels throughout the borough so that people could access services in relation to breastfeeding, child developmental checks and general health concerns. Staff told us that interpreters were used where required to ensure that parents understood their child's health needs, their treatment and could ask questions.

Leaving hospital

The health visitors told us they were informed about new births and the discharge home of new mothers and their baby in a timely manner.

Staff told us that, where children had complex needs and were due to be discharged, the health visitors were notified in advance and encouraged to attend a case conference prior to discharge. However, they also told us that this

practice was not consistent throughout all the wards. Staff also highlighted that, where specialist equipment was required in the child's home, there were no arrangements for weekend delivery. This meant that if the equipment had not been ordered within a given time period then the child would not be able to be discharged and they would stay in hospital over the weekend. The divisional leads have discussed the changes proposed around making access to equipment available seven days a week to improve the situation.

Support in the community

Obese children were monitored and national guidance was available for staff to ensure that a plan of treatment and care was in place. The minutes of recent clinical team leader meetings demonstrated that concerns around obesity were discussed and monitored. Physiotherapists noted that equipment provision such as hoists and adaptations to the home were available. However, these were not able to be delivered at weekends, which meant that some people had to spend the weekend in hospital despite being fit for discharge. We found there was a lack of occupational therapists in the community settings. The divisional leads were in the process of reviewing this and had initiated seven-day working for some areas. They plan to continue monitoring the process and increase staff if required.

Learning from experiences, concerns and complaints

Staff demonstrated a clear aim to listen to people and guide them to make a complaint if dissatisfaction was raised. We were shown some correspondence relating to complaints, which included the complaint, records of contact with the complainant and the outcome. With each complaint there were actions taken in response to issues raised, to demonstrate that learning took place as a result of complaints. For example, in response to one complaint, some staff attended additional training to improve their practice, and other issues were dealt with through performance management of staff.

Complaints were reported to the divisional director of nursing and governance who reviewed progress on complaints and incidents weekly. Staff we spoke with told us the division had good systems in place to ensure learning from complaints and incidents throughout the community services. Where people had raised a complaint, they were invited to attend a meeting as part of complaints resolution. Complaints were monitored to ensure that any themes or trends were followed up, with actions for key personnel to carry out.

People's views were taken into account so that services could be improved. We saw information that the lead nurse for breastfeeding had undertaken an audit whereby new mothers were asked about the breastfeeding information they had been provided with. The competencies and skills of the health visitors offering the advice were also audited. The trust had also undertaken a review of the children's developmental reviews, and one of the results was that health visitor provision had been increased for child developmental clinics.

Plans were being implemented regarding the changes in the school nursing service whereby they will be commissioned by the local council, with parents involved in the steering group.

Are community services for children and families well-led?

Vision and governance framework

Staff we spoke with conveyed an understanding of the trust's vision and values, which had been presented by the chief executive at 'roadshows' which staff attended. Staff told us that their managers at service level were visible, accessible and approachable. However, the majority of staff said that the board and senior managers were not always visible and they were not aware of the support or input of senior managers within the trust.

Several staff we spoke with told us that recruitment practices within the trust were not well-led as there were delays from the time of the job offer to the work starting date.

We were shown evidence of the 'Productive community services' self-audit that took place within the health visiting services, where there was increased monitoring of areas such as one-year reviews, and the monitoring of breastfeeding uptake. This also included seeking feedback from users of the services, with the most recent showing the majority of people were positive about the services provided.

At service level, scorecards were completed by managers and reported to the trust, and included monthly feedback

about areas relating to staff appraisal, training, complaints and developmental reviews that had taken place. We also saw minutes of monthly clinical team leader meetings across children and families services. Recent meeting minutes showed discussions around recruitment, key performance indicators, safeguarding concerns around obesity, pathways and patient safety incidents and whether staff appraisals had been completed.

Governance of the children and families services by senior managers within the trust took place through monitoring of service level audits in relation to supervision, record-keeping, case notes and hand-hygiene audits. Complaints and feedback received from people who used services were monitored for any trends and lessons to be learnt.

Promoting innovation and learning

Within the school nursing teams, a new school profile tool was being used across the borough to identify the needs of individual schools, so that appropriate support could be provided. We were also shown information about plans that were due to be implemented in April 2014, regarding a pilot to enable the access of young females to emergency contraception in two schools within the borough.

The trust used national and NICE guidance to base practice on. Learning opportunities were available for all staff – not only mandatory training, but also areas specific to practice, such as the autistic spectrum, and children with diabetes or epilepsy. There were specific teams for those with learning disability needs.

Leadership development

We saw information leaflets for families, encouraging feedback on their healthcare experience. We also saw completed service-specific satisfaction questionnaires at some of the clinics we visited. There were also results from recent surveys that the provider shared with us and staff across the community services; this information provided a positive picture of children's and families' experiences of services.

The intranet and emails were used to communicate internally with staff. The trust's chief executive also ran annual roadshows for staff. However, the majority of staff in community services conveyed that the information they received through these routes tended to focus predominantly on the acute services provided by the trust, and there was little information provided about changes being made to community services.

Staff engagement

Most of the staff we spoke with said that they had regular team meetings and clinical practice meetings. The records of these meetings showed that discussions took place around the service delivery, factors affecting this (such as staff sickness), and the redistribution of work to ensure that performance indicators were met. An example of this was in relation to the government's Healthy Child Programme, where health visitors carried out periodic checks on the child and their family. However, the part-time staff we spoke with said that, while team meeting minutes were conveyed to them by email, the meetings always took place on their non-work days, so they felt less involved.

Staff told us that they received communication from the trust via the intranet and through emails. However, the majority of staff we spoke with said they felt "detached" and "forgotten about" by the trust. They said they felt the information they received such as at engagement events and in the training they received, was predominantly focused on the acute services. In two community settings, some staff told us about their anxieties in relation to proposed changes in their work that were due to take effect in the coming months. However, they said they had not been consulted about this and showed us evidence of the only communication they had received on this issue.

We found that the community teams used a number of different computer systems to record information about children, young people and families, and the care and treatment they received. We were also told that, in one Genito-Urinary Medicine (sexually transmitted infections) clinic, only paper records were maintained, as the computerised systems could not ensure the confidentiality of information. The staff confirmed that the computerised systems were not synchronised to ensure that information was shared between systems. The staff said they passed information via email and fax, though confirmed that information could be missed through the different systems in use. Some staff we spoke with did not know whether the fax numbers they used to raise a safeguarding alert were secure ('safe haven') numbers. Similarly, staff said that IT systems were not always repaired in a timely way when they broke down, which could hinder their work. This

meant that records could not always be updated in a timely manner. Information from the trust indicated that the slow connections for IT systems within the community had been identified by the trust as an issue, although not the synchronisation of records. This did not impact on patient care but was frustrating for the staff.

Community services for adults with long-term conditions

Information about the service

Services for adults with long-term conditions are provided by St John's Therapy Centre. Care for adults with long-term conditions within the London Borough of Wandsworth include district nurses and specialities such as tissue viability, Parkinson's, cardiology and stroke rehabilitation. There are four community wards which consist of a multidisciplinary team working together to provide care in people's own homes during acute or prolonged health episodes to avoid admission to hospital, or to ensure a safe transition home.

During our inspection, we spoke with around 70 staff and more than 30 patients and their carers who used the service. We also accompanied community staff on visits to patients' home.

Summary of findings

Overall, we found that services provided to adults with long-term conditions were safe, effective, caring, responsive and well-led at a local level.

Staff were aware of adult protection and safeguarding. Staff reported serious incidents or concerns and the trust had good systems and processes in place for recording these. There was less clarity on how learning from safeguarding, incident reporting and complaints were disseminated to individual community team level but there were processes for communicating to clinical team leader level.

The delivery of care and treatment was based on guidance issued by appropriate professional and expert bodies and a number of care pathways were in use. We saw that staff were involved in monitoring and assessing the quality of care, including the development of guidelines and protocols. We saw and heard evidence of innovation and a proactive approach to performance improvement at local level.

Staff demonstrated a caring approach. Patients and relatives spoke highly of the care they had received. We saw staff delivering care that was compassionate, planned according to people's individual needs, and which focused on encouraging patients to maintain their independence.

We found the service was responsive to patients' needs as well as to feedback from patients and relatives. Following review of this feedback, learning was not routinely cascaded to teams.

Most staff understood the requirements of the Mental Capacity Act 2005, although there was little evidence of recently updated training. Staff were able to demonstrate an understanding of the care needs of a person living with dementia, although dementia training was not included in the provider's mandatory training programme, and we could find evidence of very few community staff having received such training.

The services provided to patients with long-term conditions are well-led at a local level, although escalation and reporting of risk above service level required further development. Staff had clearly defined

Community services for adults with long-term conditions

roles and responsibilities and there was a sufficient skills mix to meet the care needs of people with long-term conditions. There was a mostly open culture locally where staff felt able to raise concerns and could be sure that these would be acted on.

Some staff told us that they felt isolated from the acute hospital while others felt well integrated. All staff we talked with expressed concerns about the lack of an integrated IT system and prompt support for IT issues in the community. This did not impact on patient care but was frustrating for the staff.

Are community services for adults with long-term conditions safe?

Safety in the past

We saw documentary evidence that there were mechanisms in place to monitor and report safety incidents that included falls, pressure ulcers, medication errors and Never Events (incidents so serious they should never happen). There had not been any Never Events in the long-term conditions services in the last year.

All staff we talked with demonstrated awareness of the trust's systems and processes for reporting incidents. We saw evidence that incidents were monitored and discussed at monthly divisional governance board level meetings. We were also shown examples of clinical team leader meetings as well as team meetings for areas such as podiatry and the nutrition and dietetic service where incidents were on the agenda and discussed. This meant that local incidents were reported, investigated and, where necessary, actions and learning took place.

We found there were clear safeguarding systems and processes in place for reporting concerns. Staff demonstrated a good understanding of safeguarding, recognising the complexity of patients and their circumstances and the role of social services in any investigations. Staff could locate the relevant local authority contact numbers. We saw documentary evidence that safeguarding was included at the divisional level and in some clinical team leader and team meetings, but not all. Staff told us they were well supported when raising safeguarding concerns. However, some staff felt there was variation in consistency of safeguarding reporting across different teams.

We saw documentary evidence that healthcare-associated infections were monitored and that there had been none in the community division up to August 2013. We also saw that falls were monitored in community settings, but it was not clear whether this included falls in patients' homes. We visited one patient at home where their fall had resulted in a hospital admission. Pressure ulcers were closely monitored through the incident reporting system as well as weekly audits.

Learning and improvement

We wanted to see how the provider looked at incidents and used the information to improve safety for patients using

the service. We found some documentary evidence that detailed investigations called 'root cause analysis' were carried out and that action plans were developed from the findings. We saw that these were discussed at the monthly divisional governance meetings, as were safeguarding and patient complaint investigations. However, we found limited evidence that the actions and learning from incidents on the acute sites were regularly disseminated to the community staff at their team meetings. There was some evidence of learning from complaints, and pressure ulcers were regularly monitored and investigated.

We would expect that the provider would actively draw on lessons learnt from incidents throughout the organisation and also actively respond to lessons learnt from elsewhere in the organisation. Some people in the local community raised concerns about the safety of the discharge process in that they felt people they knew had been discharged, "too early." There was little evidence that this happened routinely. We saw documentary evidence that performance was regularly monitored and reviewed from team meetings up to the divisional meetings. Improvements were tracked from such initiatives as the pressure ulcer prevention work over the last two years. There was also documentary evidence of the reduction in patient falls admissions to hospital in Wandsworth as a result of the falls service's work.

Systems, processes and practice

We found that there were effective and reliable systems in place at clinical team leader level and below to enable staff to deliver safe care. Systems within individual teams identified any issues or concerns and these were acted on promptly.

There were a variety of ways in which teams delivered safe care. One example was the multidisciplinary meetings held every morning by the community staff in each of the four localities to review patients. This meant that any raised risk for a patient was identified and plans to manage and reduce this put in place. We saw that staff were supported in raising concerns and reporting incidents.

Staff told us they felt safe and supported when visiting people in their own homes. They told us that a risk assessment was completed around the premises, the person they were visiting and any potential areas of risk. The correct staffing numbers and ways of care delivery were then planned according to this. Everyone we spoke with told us they never felt unable to carry out their roles because of risk. They told us that, if two staff were needed, then this was always accommodated. Staff also demonstrated good communication and working relationships with other health and social care professionals. This meant there was a multidisciplinary approach to providing safe care.

We found safe processes and practice in place in respect of secure storage and administration of medicines. We saw that staff completed appropriate checks before administering medicines. Complete, accurate and up-to-date records of medicine administration were kept.

There were effective arrangements for managing waste and clinical specimens, particularly in patients' homes and other non-clinical environments where care and treatment were delivered. We saw evidence of this in the clinics we visited and during accompanied visits to patients' homes during care delivery by community nurses. Patients were protected against the risk of acquiring infections. We saw good practice in infection prevention and control in the day hospital and in patients' homes.

Medical and personal records were held and transferred securely and could be made available to professionals who needed them in the right place at the right time. However, a theme that came through from all staff we spoke with was the need for integrated IT systems. As not all staff could access all systems and the systems were not complementary, staff used a variety of methods to work round these difficulties to ensure the safety of patients. These other methods included printing off and using paper records and making telephone calls to obtain relevant information, all of which took a considerable amount of time. While this did not impact on the safety or care for patients it did impact on the time available for care.

We looked at the emergency medical equipment for the building. We saw that there were daily checks on the defibrillators and that the 'grab bag' (a bag containing emergency equipment) was intact. We saw evidence of the monthly checks signed as completed. Appropriate staff were responsible for the checks and there were arrangements in place for when they were absent, for example, on annual leave. Staff described the local protocols and demonstrated the pager system in place for patient emergencies.

Community services for adults with long-term conditions

Monitoring safety and responding to risk

There were mechanisms in place to monitor changing levels of risk on a day-to-day basis. The clinical and professional team leaders, together with senior and specialist nurses and care coordinators, were effective in the management of their particular services. We noted and saw evidence of timely action taken before levels of safety were compromised. There were arrangements in place to ensure that there were sufficient staff with the right skills to deliver care most of the time. There were significant vacancies in some services and we saw that staff worked hard to provide sufficient cover when required. Staff had the right skills to respond appropriately to a medical emergency while delivering care and treatment in the community.

We saw that there were guidelines and protocols in place so that staff working in the community could access advice, resources and make referrals to other health and social care professionals as needed. However, due to the IT limitations, we were told there could be some delays to patient's appointments and access to services on occasions. We found that complaints and comments from staff, patients and carers were generally listened to and viewed positively.

Anticipation and planning

Leads for each of the services communicated identified risks through the trust governance process. We found that staff were aware that there would be changes in the way some services were delivered but that some staff did not feel well-informed about these changes. We saw evidence where, for example, the diabetic service had developed a system of different levels of support for patients with referral pathways to ensure patients could access quickly additional care and treatment when required. This was done in conjunction with an increased focus on patient education to enable self-management where possible and improved understanding and compliance with treatments. In addition, staff held joint clinics with GP practices in order to skill-up practice nurses and GPs to manage the increasing number of patients.

Are community services for adults with long-term conditions effective?

(for example, treatment is effective)

Evidence-based guidance

During our observations and discussions with staff, it was clear that the care provided was evidence-based and staff followed recognisable and approved care pathways, such as diabetic and falls care. Staff were clear about their roles and responsibilities with regard to patient care and treatment.

The provider had arrangements in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and put them into practice. We saw evidence of this in care planning discussions where patients lacked capacity to make informed choices due to conditions which affected their long-term and short-term memory, for example, dementia or a learning disability.

It was of concern that many staff had not received formal training around the needs of those living with dementia. We were told of and saw plans for staff training to be put in place. Staff we talked with demonstrated varied levels of understanding and knowledge of patients living with dementia.

Monitoring and improvement of outcomes

We found systems in place that monitored and evaluated improvements of outcomes within the various teams. This was also monitored through the incident reporting process, particularly for pressure ulcers. The reported incidents and root cause analyses were all reviewed and a checklist developed for the community nurses to use to improve outcomes. The service was also working closely with the trust safeguarding lead and undertaking some clinical trials. Patients were kept under review.

Some staff had regular supervision and appraisals in place but this was not the case for all community staff. However, all staff we spoke with said they could access relevant training and continuous professional development opportunities to support them in delivering high-quality care and treatment. We found that staff were very proud of the quality of the services they provided and worked hard as a team to ensure this continued.

Community services for adults with long-term conditions

Sufficient capacity

Staff we talked with who had recently started to work for the trust described their induction programme, both corporate and with the local service. We were told they felt well-supported and had received appropriate training.

While there were staff vacancies, in most of the services we looked at staff were able to give the time to their patients in order to deliver care and treatment and not compromise quality. We saw this when accompanying community nurses delivering care in patients' homes as well as in clinics and the day hospital. Staff told us they felt well-trained and qualified for their roles.

We saw examples where services were able to initiate care and treatment very quickly. One example was the intermediate care team where they provide intensive support to patients discharged from hospital to enable them to return to as much independence as possible. Another example was the biomechanic podiatry service. As their technicians had access to their own laboratory, appropriate appliances could be provided very quickly for patients, often on the same day as their clinical assessment.

Multidisciplinary working and support

We saw examples of exceptional multidisciplinary working where staff demonstrated a commitment to promoting communication and planned care for patients. These included staff in the day hospital, the community learning disability team and the district nursing teams. We saw evidence in the patient records we looked at as well as in discussion with patients and observation in multidisciplinary meetings. Staff demonstrated that they shared information appropriately with other healthcare professionals in different parts of the trust as well as with external agencies. Staff demonstrated good relationships for onward referral, for example, to social services. These were integrated multidisciplinary teams with access to a wide range of health and social care services. Staff worked with hospital discharge coordinators to ensure a good discharge with appropriate support for patients.

The patients and their carers were at the centre of the multidisciplinary working and planning. They told us how they were encouraged to be involved in their care and we saw they were listened to. We saw many examples where staff had initiated contacts to ensure that patients' needs were fully met and therefore increased the chances of a better outcome for them. Many staff we talked to, when asked what they were most proud of, immediately said that it was their multidisciplinary team working. The barrier they identified was, again, the lack of an integrated IT system.

Are community services for adults with long-term conditions caring?

Compassion, dignity and empathy

We saw many exceptional examples of staff demonstrating compassion and treating patients with dignity and empathy. We held a listening event so that people in the local community could tell us about their experience of the community healthcare. We were told by many people there of the "dedicated staff" and the care they, or their loved ones, had received. We saw where 'best interests' meetings had been held for20140327 St John's Therapy Centre Quality report April 2014 - DRAFT 25patients who were unable to make decisions for themselves. These involved the patient's family members, or if there were none, the local advocacy service. We saw the decisions made were thoughtful, with great care taken to maintain the patient's dignity.

Involvement in care

We saw documentary evidence that patients and their families or carers were involved in decisions about their care in the patient records we looked at. We also observed it when accompanying community nurses on visits to patients' homes. Information was provided and, for those with capacity to understand, each step in any proposed treatment was discussed. Patients were given time and support to make informed choices. Patients told us that they understood their care and treatment and were able to ask questions if they were unsure about anything. Patients told us they were kept informed and treated with respect. We saw examples of information provided to patients and staff told us they could provide information in different and accessible formats. We saw where staff helped patients navigate other areas of support available to them external to the trust's community services.

Trust and respect

We saw that staff were able to communicate effectively with patients, adjusting language and the method of providing information to suit each individual. They always announced themselves and explained what they were there to do. Patients told us that they trusted staff to care

for them and keep them informed. We saw where staff supported patients to attend other services such as an outpatient appointment, if required. Staff maintained patient confidentiality and protected their personal information.

Emotional support

We saw evidence of the care and support in place to enable a patient to remain at home for their end of life care. Staff told us what a key part of their job this was and how they worked together with others to achieve each patient's preference. They described how they raised end of life issues with patients in order to gain insight into their preferences. Staff demonstrated how they provided good pain management for patients.

There were examples of support provided to return to or maintain a patient's independence, such as the diabetic educational programme and the intermediate care team's work. Staff provided the support and information to allay any anxieties expressed. We saw the holistic care provided to patients who attended the day hospital. A major part of the community learning disability team's role was to provide emotional support and carefully communicate information to support patients, particularly when having their medical needs met.

Are community services for adults with long-term conditions responsive to people's needs?

(for example, to feedback?)

Meeting patients' needs

We saw evidence that staff took account of patients' views when evaluating what the next steps would be, including where they would be best placed to receive services. Patients told us that they felt able to influence what was happening to them. We saw that where a patient was anxious, staff reassured them and said they would contact them in the next couple of days to see how they were. The patient was happy with this solution. We also saw where a patient's risk had increased and this was discussed at the morning multidisciplinary meeting, and daily visits were put in place. Patients' care goals included their ability to manage their condition independently, or with support. This reassured patients that they would only be discharged from the service when the time was right.

We received positive feedback from all of the patients we talked with during our visits to the day hospital, outpatients clinics and while accompanying district nurses to home visits with patients. One of the main aims of home visits by the community nursing teams and specialist nurses was to avoid patients having to be admitted to hospital and, overall, this was being achieved.

Access to services

Patients told us that, on the whole, they could access care and treatment when and where they needed it. They spoke highly of the environment at St John's Therapy Centre and said that their GP had referred them into the service and that it had worked well. The various services had admission criteria that were applied20140327 St John's Therapy Centre Quality report April 2014 - DRAFT 26and care pathways, guidelines and protocols were in place. The staff helped patients access any additional services they needed, whether internally or externally.

Staff had training in equality and diversity and it was evident when speaking to patients that people who lacked capacity or had physical impairments were able to access the service they needed. We saw evidence where staff had referred patients on if it was felt that another service could better support them or if it was more appropriate for their care and treatment. We saw that staff explained any changes to patients.

Vulnerable patients and capacity

In all the community services we looked at, nurses, allied healthcare professionals, healthcare assistants, technicians and other staff all managed their time effectively to ensure they were flexible to the needs of each individual patient. All care and treatment was tailored to the individual patient. This was achieved through the morning meetings that many of the teams and services held where individual planning was discussed, based on the indepth knowledge of each patient's needs. Those who were vulnerable or lacked the capacity to make decisions for themselves were catered for and plans made for 'best interests' meetings where appropriate.

Some staff told us that 60% to 70% of the patients on their caseload had some form of dementia type illness, learning disability or mental health illness. Some staff told us they were concerned for people with mental health illnesses as it was sometimes difficult to access the support they needed. We saw that the specialist mental health nurse attended one community nursing team's multidisciplinary

meeting and was able to put in the support when required. The community learning disability team clearly demonstrated that they had the time required to ensure that their patients received a quality service that responded to their changing needs. We saw how the day hospital staff highlighted particular concerns about any patients so that these could be investigated while they were attending the day hospital.

Leaving hospital

Community-based staff engaged with hospital discharge coordinators to ensure a good discharge with the appropriate support in place. We saw evidence of planned support in the patient records we looked at. Staff said that sometimes the discharge information was not complete, in which case they would contact the appropriate people to ensure that they got all the information they required. If a patient was not referred to the most appropriate part of the service, this would be picked up at this point and amended.Staff told us they could access a range of equipment to make sure patients received appropriate care. However, we were told that larger items of equipment were not available at the weekends and that could delay discharge on some occasions.

Learning from experiences, concerns and complaints

Staff described to us how they responded to any concerns or complaints raised directly with them by patients. They also described the annual survey of patients the organisation undertook across all their services. Analysis of the patient survey carried out in 2012/13 showed positive results across the board. The 2013/14 patient survey was currently being analysed but early indications were that the results would also be positive. The results will be made available to staff and patients.

The community teams were also making comment boxes available for patients and were keen to demonstrate a positive response to suggestions made where possible. We saw that patients were listened to by staff.

Staff we talked with all mentioned problems with the IT systems. One frequent issue was where equipment broke down. Staff felt that the support service provided by the trust was not responsive to their needs and that it took a long time to either repair or replace items. For example, a scheduled IT system upgrade would not benefit the whole team due to an overall shortage of working computers. We saw broken computers and printers piled up on one end of a table in the administration office.

Are community services for adults with long-term conditions well-led?

Vision, strategy and risks

Overall, staff were aware of the vision and strategy in place for the organisation. The values and objectives had been shared with staff and they said they received corporate information by email.

However, we received varied responses in respect of staff feeling a sense of belonging to the whole trust. Some staff had meetings with their acute hospital colleagues and felt well-integrated and felt that links were developing well. Other staff felt very isolated and excluded. We were told that communications felt very “acute orientated”, as did training. Staff felt some training lacked relevance for community staff. Staff felt that the IT issues were a considerable risk to the quality of their service, as well as some concerns about staffing levels. However we saw that the IT issues did not impact on patient care.

Quality, performance and problems

We found good reporting systems for quality and performance at clinical team leader level and above. It was less clear how some of the individual teams contributed to, or how risks and problems were raised through, the whole system.

Staff described some of the difficulties in having different geographical boundaries between the community and the acute parts of the trust. Some of the staff worked across boroughs and found the different working practices and the need to identify with different acute services a challenge. The divisional leads stated that they were aware of the issues and were involved in regular meetings and discussions across boroughs. This included liaison with the relevant clinical commissioning groups, such as Merton, as well as acute trusts, the King’s Fund, Guy’s and St Thomas’ as well as the Royal Marsden.

Leadership and culture

Most staff we talked with knew the senior leadership of the organisation but they identified a gap between the executive and their clinical team leaders. Many staff felt

that middle to senior managers did not visit the community localities and did not have a real knowledge of the work the community staff did or the complexity of the needs of the patients they cared for.

Almost all the staff we talked with were positive about their individual managers and felt well supported by them. They spoke of excellent team work and a real sense of belonging to the community division. They felt listened to and that they had a voice. One group of staff expressed concerns about their local management and these were discussed with the executive team at the time of the visit. We also raised the concerns of staff about the perceived lack of presence of the divisional leads in the community. The executive team stated that they would look at ways of addressing this. The divisional operations manager had an office based in the Queen Mary Hospital but the divisional chair clearly recognised the need to raise their profile among all the community staff.

Patient experiences and staff involvement and engagement

We found good systems in place for recording patients' experiences and these were collated and presented as a report twice a year to the division governance meeting. There were also annual patient surveys and other initiatives such as comment boxes in community service areas.

'Listening into Action' sessions have been held in some community settings and staff who attended were positive about the event and felt they had been listened to. Other staff felt they had not had an opportunity to attend. There was also a feeling that decisions, such as changes in uniforms, were taken at a higher level, with no opportunity for community staff to be included in any consultation.

Learning, improvement, innovation and sustainability

Generally, staff had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Training data showed that the majority of staff had completed their mandatory training. Staff said that the trust's system to prompt them with an email when their update training was due worked well. Staff also told us that they were able to access other training relevant to their role and that they were well supported in this. However, there was minimal evidence of community staff having had dementia training, although the staff we spoke with felt able to provide the care needed.

We found innovative care and treatments in several areas of community services that we looked at, notably in the falls service, tissue viability and diabetes services. This, together with the exceptional multidisciplinary working seen throughout the services we looked at, and the care and compassion demonstrated, created an accessible and high-quality service based around individual patients. Staff were proud of their achievements and the quality of service they provided. We found much energy and enthusiasm to continue to improve.