St George's University Hospitals NHS Foundation Trust

RJ7

Community health services for adults

Quality Report

St Georges Hospital
Blackshaw Road
Tooting
London
SW17 0QT
Tel: 0208 672 1255
Website: www.stgeorges.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ7X5	Nelson Health Centre	Community Services for Adults	SW20 8DB
RJ7X3	Queen Mary's Hospital	Community Services for Adults	SW15 5PN
RJ701	St George's Hospital (Tooting)	Community Services for Adults	SW17 0QT
RJ760	St John's Therapy Centre	Community Services for Adults	SW11 1SW

This report describes our judgement of the quality of care provided within this core service by St George's University Hospitals NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by St George's University Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of St George's University Hospitals NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated this service as good because:

- There were appropriate risk assessment and monitoring process to ensure that patients were safe when using the service.
- Treatment was planned and delivered in line with national guidelines and the outcomes of this were monitored.
- Staff were kind and caring towards patients and made sure that people understood the care and treatment they were receiving. The patients and their relatives that we spoke to confirmed this.
- There were innovations being planned and underway to improve the quality of services people received through better team work and greater integration of services.
- Local teams worked well internally and with each other and there was a culture of staff providing safe, high quality healthcare to patients.

However:

- Improvements were needed to the record keeping systems to ensure that all staff had access to the right systems and at the right time – and remote access should also be considered.
- Staff vacancy rates meant that adjustments to when patients were seen were often needed, staff had to actively manage these risks and the service was heavily reliant on bank and agency staff.
- Staff within the service did not feel connected to the Trust as a whole and there was limited leadership or strategic direction from the senior Trust team.

We rated this service as good for safety because:

- People underwent appropriate risk assessments when they first started using the service and their safety was monitored throughout.
- Staff knew how to keep people safe from abuse and what to do if they had any concerns about patients.
- Staff received appropriate mandatory training in a range of topics.

However:

- Not all lessons learnt from incidents were shared across different teams.
- Multiple record systems were used and access was not always available to all, meaning important information might not always be available to relevant staff.
- Staff vacancy rates meant the service was heavily reliant on bank and agency staff in some areas and the service had to regularly rearrange its programme of work to adjust to staff absences and manage patient risk.

We rated this service as good for effective because:

- Staff followed up-to-date national guidance when providing care and treatment and monitored the outcomes of treatment.
- The multi-disciplinary teams worked well together involving a full range of professionals in people's care and treatment.
- Staff had a good knowledge of the Mental Capacity Act as well as what actions to take if they were concerned about someone's capacity to make a decision.

However:

- Staff's access to patient information was limited at times and a lack of remote working technology had a significant impact on the efficiency of the service.
- Workload pressures and a lack of suitably trained staff could result in clinical supervisions not taking place or being delayed.

We rated this service as good for caring because:

- We observed staff providing care and treatment in a kind, considerate and caring fashion.
- The people we spoke with and their families described staff as "friendly", and "very nice".
- All of the patients that we spoke with said they understood their care and treatment and we observed staff providing these explanations.
- In written feedback patients rated the service highly in terms of the way they were treated by staff as well as understanding their care and treatment.

We rated this service as good for responsive because:

- There were numerous initiatives underway to alter and redesign the model of care being provided to better support the needs of people using the service and provide better outcomes.

Summary of findings

- Arrangements were made so that people whose first language was not English or who had communication difficulties were supported when in contact with the service.
- Complaints were responded to appropriately within set time scales.

However:

- Whilst staff actively worked to minimise patient risk, the staff vacancy levels meant that low risk patient appointments were often rescheduled and at previous time significant waiting lists had built up for some services.

We rated this service as requires improvement for well-led because:

- Whilst there were examples of local leadership there was limited evidence for any overall strategy for the service from a trust level.
- There were concerns expressed by staff over recent changes to working patterns, duties and rising workloads. These concerns were expressed across several teams and were having a significant effect on staff morale in certain areas.
- Staff in general did not feel connected to the Trust as a whole and felt that the community services in general did not receive appropriate focus or consideration on a senior trust level.

However:

- There were numerous local initiatives in place and being planned to improve the quality of the service which were in line with NHS Strategic priorities to further integrate services and achieve efficiencies.
- Service level staff and teams were dedicated to providing high quality, safe, compassionate care for patients, as well as working as a team and helping each other where needed.

Summary of findings

Background to the service

Community health services for adults covers several services including community nursing services for adults (including district nursing teams), therapy services, intermediate care and rehabilitation services. These can be delivered from clinics or in people's own homes. They support people in maximising their independence, facilitating discharges and managing complex health conditions. A total of 55 services are provided from a number of locations, including 32 outpatient clinics.

The service mainly provided services to people within the London Borough of Wandsworth. Between June 2014 and June 2015 the service saw over 400,000 patients in its clinics alone, in addition to which they visited people in their own homes.

On the inspection we visited four of the clinics (including the headquarters for the service) and accompanied staff when they visited people in their own homes where we observed care, treatment and support being provided. We spoke to 62 members of staff as well as 29 patients or their relatives. We reviewed policies and performance data and looked at 15 copies of patient notes.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper

Team Leader: Nick Mulholland, Head of Inspection CQC

The team included CQC inspectors and a variety of specialists: Occupational Therapist, Physiotherapist, Speech and Language Therapist, Nurse Specialist, General Practitioner.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 21st, 22nd and 23rd June 2016. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 4th July 2016.

Summary of findings

What people who use the provider say

We spoke to patients receiving care and treatment. They told us that the service was "good" and that they had "no complaints". They described staff as "friendly", "caring" and "very nice". Patients that we spoke with confirmed that they understood the care and treatment that was being provided to them, that they were involved in decisions about their care and they understood everything they were told.

We looked at the results of recent patient feedback in which the majority of respondents said that they were treated with respect and staff presented themselves in a professional manner. They said that they understood the care and treatment that was being provided.

Good practice

- Senior staff spoke positively of their community MDT teams which featured a full range of professionals including nurses, GPs and therapy staff. They met on a regular basis to discuss the full healthcare needs of patients. Staff told us that this had made improvements to patient outcomes with reduced Accident and Emergency department attendances and acute admission rates and we saw evidence of this.
- The service was working with local GPs to set up 'Enhanced Care Pathways' for patients who frequently attended and used acute services to try and prevent admissions.
- There was a dedicated falls service which was being developed around the physiotherapy department. The aim was to have this service integrated with the maximising independence service, the acute accident and emergency department and the orthopaedic and osteopathy services. Working across these services they were aiming to target young and old people who could benefit from ongoing monitoring and earlier intervention. It also included further education services for patients as well as peer support and further sporting or other physical activity sessions in the community run by volunteers.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Staff should ensure that relevant lessons learnt from accidents and incidents should be shared across different teams.
- All relevant staff should be able to access all of the records and record systems holding patient information where appropriate. Options to enable them to access this information and input further information remotely should be actively explored.
- Staff vacancy rates should be addressed as soon as possible.
- In conjunction with senior Trust staff a longer term vision and strategy for the department should be developed and implemented with clear goals over the coming years and clear methods for achieving them.
- Senior Trust staff should liaise with senior and junior service level staff to ascertain from where the atmosphere of isolation from the Trust as a whole originates and work with them to address this.
- Senior service staff should work closely with junior staff to ascertain the precise nature of their concerns over changing work patterns, duties and workloads, and work to mitigate the impact of these wherever possible, as well as their impact on staff morale.

St George's University Hospitals NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- People underwent appropriate risk assessments when they first started using the service and their safety was monitored throughout.
- Staff knew how to keep people safe from abuse and what to do if they had any concerns about patients.
- Staff received appropriate mandatory training in a range of topics.

However:

- Not all lessons learnt from incidents were shared across different teams.
- Multiple record systems were used and access was not always available to all, meaning important information might not always be available to relevant staff.
- Staff vacancy rates meant the service was heavily reliant on bank and agency staff in some areas and the service had to regularly rearrange it's programme of work to adjust to staff absences and manage patient risk. However, staff said that this was not currently adversely affecting the safety of the service and patients were positive about the quality of the service they received.

Detailed findings

Safety performance

- District nursing teams used a monthly "safety thermometer" by which important performance information was monitored such as number of pressure ulcers acquired or falls. However, staff that we spoke with were unsure of the purpose of the thermometer. We reviewed data relating to these incidents which did not indicate any serious issues with the safety of the service.
- Podiatry staff were trained in how to spot the signs of pressure ulcers.

Incident reporting, learning and improvement

- Staff reported incidents using an internal Datix system.

Good

Are services safe?

- Between April 2015 and May 2016 zero Never Events took place in the service. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never Event.
- Six serious incidents had taken place – four grade three pressure sores and two grade four pressure sores. A total of 407 incidents had been reported by the service but 91% of these were reported as low or no harm.
- Incidents were reported at the monthly divisional governance meeting including details of the actions plans put in place as a result. Senior staff were required to produce evidence that actions had taken place.
- Most staff told us that they heard about incidents which occurred in other areas of the service and the lessons to be learnt from them. However, some district nursing staff told us that incidents were primarily tackled at a local level and that they did not receive learning or feedback from incidents that took place in the wider directorate.

Duty of candour

- Staff that we spoke with understood their role in duty of candour and the need to be honest with patients where mistakes were made as well as to provide an apology and to offer support to the patient.

Safeguarding

- All staff were trained to recognise signs of abuse. There was a policy and procedure in place for escalating any safeguarding concerns including reporting them to the local divisional hub, using datix and also informing the local authority safeguarding team.
- Staff that we spoke with were able to tell us about signs of possible abuse and the actions they would take to report them.
- There was an official safeguarding meeting every quarter to discuss any broad issues that had been raised. These were also discussed at local team meetings and at handovers.
- We observed staff discussing safeguarding issues of individual patients at the complex case MDT. All key workers involved in a person's health and social care were present at these meetings. Staff displayed a good working knowledge of when the risk of abuse may be high.

Medicines

- The district nursing staff that we spoke with said that medications could be accessed readily, though it was reported that there might be isolated problems accessing some end of life medications.
- Where medications were stored in clinic fridges there were records to show that the temperatures of the fridges were checked regularly to ensure that medications were stored at the appropriate temperature range.
- Other clinic medications, including controlled drugs were stored in locked cupboards

Environment and equipment

- The different environments the therapy teams provided services at were all individually risk assessed.
- Therapy staff that we spoke with said they had the appropriate equipment to be able to do their jobs. Training was available on how to use specialist equipment.
- There were local systems in place to check that equipment was cleaned and calibrated properly, and staff reported that the equipment's electrical safety was also checked.
- Equipment for treating people in a medical emergency (including AEDs) was readily available at treatment sites. There were regular checks on these to ensure that they were in good working order.

Quality of records

- We reviewed care plans and patient records for patients visiting clinics as well as being seen in the community. In general they included specific goals and there were review dates of these goals recorded. Appropriate risk assessments had been completed and there were records of MDT discussions and involvement in planning. Entries made were usually signed and dated by staff.
- However, within district nursing teams three sets of notes were usually kept; one set on a computer system, one held by the patient and one held in the office. This meant that important information may not be easily

available to district staff when they needed it. It also meant that working with colleagues from other teams to ensure a joined-up approach to people's healthcare could be difficult. There were no specific protocols of what was recorded where and what needed to be duplicated across all records.

- There were also issues regarding the complex case team where the care was coordinated by the GP as they used a separate system ("EMIS") for recording their notes. However, some staff based in clinics were positive about the RIO computer system which they used for all their documentation and communication between other teams.

Cleanliness, infection control and hygiene

- We observed staff providing care and treatment to people in their own homes. Appropriate personal protection equipment was used and staff followed appropriate hand hygiene protocols.
- The clinics that we visited were visibly clean and tidy. Alcohol gel was available throughout and there were signs on the walls about the importance of hand sanitation. There were facilities for the decontamination of equipment where needed. There were daily cleaning schedules for the facilities that were used.
- Staff in clinics were observed to follow appropriate hand washing protocols and use personal protection equipment as appropriate.

Mandatory training

- Mandatory training covered appropriate topics such as Fire Safety, Safeguarding and Health and Safety. Information specific to the community Adults service was not available but across the directorate the individual teams had compliance rates on average above 80%.
- Senior staff said they were content with the levels of mandatory training undertaken by staff. This took place by computer and staff were sent automatic reminders when they needed to complete a particular course. There was protected time for training.
- The nursing and therapy staff that we spoke with said that they were up to date with their mandatory training and that they were given the time to do this.

Assessing and responding to patient risk

- When patients first started using services they underwent a full risk assessment to ensure that it was safe to do so. They were asked about appropriate factors such as current and previous health problems, medications being taken and family history of illness. They were assessed, where appropriate, for specific risks such as the risk of falls and eating and drinking.
- Senior staff reported that when their daily monitoring of staffing levels showed a staff shortfall they would often need to rearrange visits. Patients with the greater needs or at greater risk were prioritised.
- For a complex case patient, the appropriate risk assessments the patient needed to undergo were discussed at the MDT meetings. We observed one of these meetings and saw that, according to the risks a person faced, appropriate assessments and action plans were decided on and given to the appropriate member of staff.
- There were procedures in place in what to do if people had a heart attack whilst using the community clinics.
- Therapy staff reported that when staffing levels were reduced they would reduce the number of patients they were seeing accordingly so that the safety and quality of the service they were providing was maintained.

Staffing levels and caseload

- There was a daily check on activity and staffing levels to check that there were no shortfalls.
- Senior staff reported that they had a vacancy rate of approximately 30% within their community nursing team which they said was in line with the recruitment picture across London. They tried to fill these vacancies with bank staff but there was also a lack of bank staff. This resulted in a fill rate of approximately 80-87%.
- We reviewed staffing data that indicated that whilst staff vacancies had been addressed in some areas there were ongoing issues in others.
- Staff reported that the local high cost of housing and living did hamper their ability to recruit and retain some staff on lower pay grades, particularly nurses. Following the inspection, the trust told us that the adult therapy services in community services, experienced difficulty in recruiting occupational therapists and physiotherapists.
- Significantly, staff reported that they did not yet feel that these vacancy and fill issues were compromising the safety of their patients, though it was impacting on waiting times and the number of rearranged appointments.
- We reviewed work programme data which indicated that caseload sizes had been broadly consistent over

the last twelve months, with the exception of the facilitated and supported discharge team which had experienced a significant increase in size. In addition some therapies staff said that their caseloads had been increasing significantly over the past year.

- District nursing staff that we spoke with said they were happy with the size of their caseloads at this point.

Managing anticipated risks

- There were specific risk assessments for use by staff to consider the risks that they might face in a patient's home. These included dog ownership, racial prejudice and transporting sharps.
- Staff who worked in the community told us that if there were concerns that a patient may become aggressive or violent they could arrange for two staff members to attend.
- Risk assessments were undertaken to ensure it was safe for people to store oxygen in their own homes. The respiratory team operated a weekend telephone 'on call' system by which they could be contacted. Patients with Chronic Obstructive Pulmonary Disease were given a home 'rescue pack' so that if they experienced difficulties out of hours they could follow the self-management plan and care for themselves.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Staff followed up-to-date national guidance when providing care and treatment and monitored the outcomes of treatment.
- The multi-disciplinary teams worked well together involving a full range of professionals in people's care and treatment.
- Staff had a good knowledge of the Mental Capacity Act as well as what actions to take if they were concerned about someone's capacity to make a decision.

However:

- Staff's access to patient information was limited at times and a lack of remote working technology had a significant impact on the efficiency of the service.
- Workload pressures and a lack of suitably trained staff could result in clinical supervisions not taking place or being delayed.

Detailed findings

Evidence based care and treatment

- Team leaders that we spoke with said they were satisfied that they were providing care and treatment in line with National Institute for Healthcare and Clinical Excellence (NICE) and other national guidelines.
- In the cardiology service there were local and national policies and guidance for staff to follow. These were last reviewed two years previously, though it was not clear when their next review was scheduled for.
- Across the service we found many examples of teams using national guidance to inform their practice. The podiatry team used NICE guidance to inform the podiatry care they gave to diabetic patients. The respiratory team had research plans to enable them to update their competency assessment framework for inhaler devices. They kept copies of guidelines for new staff on various topics including history taking and clinical examination. The dietetics and physical therapy teams were able to demonstrate their use of college guidelines in their work. Patients referred to the amputee service were screened in a pre-assessment unit using set criteria based upon the Hull model of care. They also used British Association of Chartered Physiotherapists in Amputee Rehabilitation (BACPAR) 2006 guidelines to help determine the care and treatment for lower limb amputees, as well as further BACPAR guidelines in other areas of their care.
- Specific 'nursing' meetings were held where new guidance could be raised and discussed.
- The district nursing staff that we spoke with said that they were aware of where to access the most up to date treatment guidelines.

Nutrition and hydration

- The nutritional intake and hydration levels of patients were monitored as appropriate. This was discussed at handovers.
- There were specific tools (based on national guidelines) that were used to assess nutrition and hydration.
- The community LD MDT had input from the dietics team.

Technology and telemedicine

- Staff noted that whilst 'mobile' and 'remote working' technology was available in other areas in the Trust they did not have access to this. This had a significant impact on staff as it meant that they had to attend local hub sites in order to access certain pieces of patient information or upload details of any care, treatment or support they had provided to someone's record. There were significant time implications for this, access to computers at the bases could be difficult and that on occasion the quality of IT hardware was very poor.
- Staff reported that there were issues with compatibility between the community healthcare computer systems and the acute healthcare systems.

Patient outcomes

- The division had an audit calendar and all teams took part in audits. These include pharmacy audits. However,

information on the outcomes of audits was not always readily available at a corporate level. We had asked for a sample of the results of these audits but the Trust central team was unable to provide them.

- Some teams used standard health outcome assessment tools (EQ-5D) to monitor the quality of the care they were providing. The occupational therapy team was also trialling the use of a standard assessment and outcome measurement tool to monitor the quality of their service (the Community Dependency Index).
- The amputee service used British Association of Chartered Physiotherapists in Amputee Rehabilitation (BACPAR) accredited outcome measures to monitor their performance. These included the EQ-5D, time to 'get up and go' and the 'sit to stand test'.
- For patients with specific conditions, such as strokes or motor neurone disease, specific outcome measures were used to evaluate the quality of care that was being provided.

Competent staff

- Senior staff said, in their opinion, the supervision and appraisal system was robust. Team leaders echoed this and said they were content with the current completion rates of supervisions and appraisals. They said that they went out on visits with staff on a regular basis to check on performance but also to get feedback from patients.
- Senior staff reported that they were currently developing the training for nurses building in more shadowing opportunities and further competencies. The 'train the trainer' model was being used in which less experienced trainers were receiving tuition to be able to train others in a wider range of more complex topics. They were also working with the pharmacy department to try and develop healthcare support worker roles.
- Team leaders and junior staff reported that the complexity of patients receiving therapies in the community was increasing but at the same time recent retirements had reduced the skill mix of staff. They said that there was a strong emphasis on completing mandatory training.
- However, all staff noted that staffing capacity issues could result in training, supervisions or appraisals being delayed as staff were needed to fill in for absences. In addition, a lack of specialist staff could result in skilled appraisers not being available.
- The maximising independence team had an induction checklist to ensure that new staff understood how the service worked and the local policies and procedures.
- Some district nursing staff told us that clinical supervisions did not take place and this was echoed by some of the staff in clinics. Some staff expressed concerns that access to suitably specialised staff to undertake some specialist clinical supervisions was limited, or that the only time for this to take place would be at the expense of seeing patients. Some staff also expressed concerns about not being able to access external training due to budgetary constraints.
- Therapies staff were rotated between the acute and community services which staff described as good for building skills.
- Several staff members described the recruitment process at the Trust as cumbersome and time consuming which hampered staff's ability to recruit to vacant posts.

Multi-disciplinary working and coordinated care pathways

- The 'Maximising Independence' team worked with a range of other teams to bring a holistic approach to the care and treatment they provided. This included a multi-disciplinary assessment process and clear sign-posting to other services.
- All staff were very positive about the 'complex case' multi-disciplinary team (MDT) meetings which featured a full range of staff involved in providing care and treatment including a GP, nurses, therapists and social workers.
- We looked at people's records where they were under the care of the complex case MDT. These showed that information was shared between all relevant partners. However, some staff said they would like further integration with the local mental health teams.
- We observed district nursing handovers were well-managed and comprehensive. The condition of individual patients was discussed and decisions were made on the course of treatment to take. Staff themselves said that communication within the service was good.
- There was a dedicated falls service which was being developed around the physiotherapy department. The aim was to have this service integrated with the maximising independence clinic, the acute accident and emergency department and the orthopaedic and

osteopathy services. Working across these services they were aiming to target young and old people who could benefit from ongoing monitoring and earlier intervention. It also included further education services for patients as well as peer support and further sporting or other physical activity sessions in the community run by volunteers.
- Staff that we spoke with at all levels described good MDT working amongst colleagues and said they maintained close relationships with them.
- Staff at the learning disability (LD) service told us that they maintained close links with their full MDT and met with them on a regular basis. This team included input from therapists, psychologists, nurses and psychiatrists. There were two specific LD nurses in the acute team at St George's who would contact the community LD team if a person with learning disabilities was admitted.
- For people under the care of the St George's LD community team a note could be made on their GP record to indicate that if they were to be admitted to hospital via the London Ambulance Service they should be taken to St George's rather than other nearby hospitals.

Referral, transfer, discharge and transition

- There were specific written protocols for the referral of patients to specific nursing and therapy services.
- Discharged patients from the respiratory service were given self-management plans which included details of their named nurse and their local clinic and clear instructions on what to do if they became unwell.
- The respiratory service also operated a triage system on its referrals to make sure that patients with the greatest needs were seen first.
- Clinic staff were very positive about the staffing stability within the transport team and said that they had assisted in identifying patients at risk (such as patients appearing unwell or at risk of self-neglect).
- However, staff expressed concerns about the quality of discharge arrangements made at St George's hospital stating that there were often issues with the medicines being prescribed and their recording.

Access to information

- Due to no remote working, IT capacity, and different parts of the service holding their own records, access to relevant information could be difficult as staff would need to attend a local site to either access a computer or physical records. However, following the inspection, we were advised that mobile working was being developed in some services.
- In addition, some relevant staff groups (such as therapy services) were not always allowed to access the computer systems used by other groups (such as the RIO system used by some clinic nurses) when the information recorded there was of key importance to people's ongoing care and treatment.
- We spoke to some staff who may have not been following appropriate guidance for the use and storage of records offsite. This included not signing notes in and out of local hubs where they were stored and not storing them in zip-lock bags. Some staff we spoke with were not aware of any specific protocols round this.
- Team leaders expressed frustration that some of the audit and performance data used for reporting had to be manually put together and that the IT systems used were not able to collect it automatically.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- There was mandatory training on the Mental Capacity Act and consent, as well as dementia awareness.
- Staff reported that a significant number of the people they provided services for were living with dementia and that they were used to dealing with issues such as refusal of medication and self-neglect. Senior staff were confident that junior staff were assessing these situations and responding appropriately.
- The service had access to independent mental health advocates. Speech and language therapists were also used to help people communicate and MDTs to discuss care and treatment.
- Mental capacity issues and possible best interest decisions were discussed at complex case MDTs and staff displayed a good working knowledge of the Mental Capacity Act and Deprivation of Liberty legislative requirements during these meetings.

Good

Are services caring?

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

Summary

We rated caring as good because:

- We observed staff providing care and treatment in a kind, considerate and caring fashion.
- The people we spoke with and their families described staff as “friendly”, and “very nice”.
- All of the patients that we spoke with said they understood their care and treatment and we observed staff providing these explanations.
- In written feedback patients rated the service highly in terms of the way they were treated by staff as well as understanding their care and treatment.

Detailed findings

Compassionate care

- Staff demonstrated a clear focus on the quality of care they were providing to patients. They were empathetic towards patients’ concerns and understood their needs.
- We spoke to patients receiving care and treatment. They told us that the service was “good” and that they had “no complaints”. They described staff as “friendly”, “caring” and “very nice”. This applied to both patients being treated in clinics as well as in their own homes. Staff spoke in a respectful manner to patients in all of the observations we made.
- We looked at the results of recent patient feedback in which the majority of respondents said that they were treated with respect and staff presented themselves in a professional manner.

Understanding and involvement of patients and those close to them

- We observed district nursing staff as they treated patients in their own homes. Throughout their time with the patients they provided full and appropriate answers to questions about the care and treatment they were providing. They were sensitive to any communication needs that patients had and worked with them patiently to overcome these. They explained what they were doing and took verbal consent from patients when appropriate. We observed one example where a nurse had adapted her communication methods to suit the needs of the patient (including lip reading and use of written communication) where the care was still delivered in a patient fashion.
- We looked at the results of recent patient feedback. In this patients told us that they were involved in decisions about their care and they understood everything they were told.
- Patients that we spoke with confirmed that they understood the care and treatment that was being provided to them. They were involved in setting their own treatment goals for what they wanted to achieve, as were their carers when appropriate.
- Patients were told how to contact other services by staff members as appropriate. There were leaflets available about all community adults health services which detailed what the different teams did and how to contact the service. This included details of how to contact them out of hours. They were also told how to contact local advice and support services as well as the Patient Advice and Liaison team.

Emotional support

- The staff we observed treating patients showed a keen awareness of the emotional needs of patients and aimed to meet them wherever possible.
- The patients that we spoke with said they felt well supported by staff in both their own homes and the clinics. One patient told us how they had been assisted in accessing local mental health services for further care and treatment.
- Staff told us that they could have preliminary discussions with patients about end of life care if they wanted it.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- There were numerous initiatives underway to alter and redesign the model of care being provided to better support the needs of people using the service and provide better outcomes.
- Arrangements were made so that people whose first language was not English or who had communication difficulties were supported when in contact with the service.
- Complaints were responded to appropriately within set time scales.

However:

- Whilst staff actively worked to minimise patient risk, the staff vacancy levels meant that low risk patient appointments were often rescheduled and at previous time significant waiting lists had built up for some services.

Detailed findings

Planning and delivering services which meet people's needs

- The service kept track of the ongoing demands placed on individual teams and the size of their caseloads. They noted that there had been an increase in the demand on their services which had put pressure on the service, and this had been flagged on the directorate-wide risk register.
- Numerous initiatives were being undertaken to improve the services for patients so that it better met their needs and would also improve the efficiency of the service (including financial). These include setting up a single point of access to address both physical and mental health needs for patients with learning disabilities; a falls prevention team to reduce admissions and lengthy rehabilitation times; setting up 'Enhanced Care Pathways' so that provision for the most frequent users of services was better coordinated and more focussed on prevention and intervention.
- Staff told us that there was limited space available at Tooting Health Centre. This meant that some patients had to wait standing up and it also reduced the ability of staff to see a high volume of patients when there were pressures on the service. There had also been previous problems with flooding.

Equality and diversity and meeting the needs of people in vulnerable circumstances

- Interpreters were available to district nurses and could be accessed as needed. Sign language interpreters were also available as needed.
- Staff said they could order leaflets and other pieces of information to be translated into other languages, but these were not available as standard.
- Staff could undertake the Dementia Friends training in which they would learn more about dementia about how to better help people who were living with it. Dementia awareness training was also part of the mandatory training programme.
- There was a specific Learning Disability (LD) community team which provided care, treatment and support to people with LDs in the community. They had 'LD Passports' which were used to document their specific treatment needs and details of the way in which they wanted to be cared for. They took these with them to other health services when they attended so staff were aware of their needs. Nursing staff checked that these passports were up to date when they visited.
- There were easy-read assessment consent forms available, as well as an easy read version of the Friends and Family Test and Patient Advisory and Liaison Service leaflets.

Access to the right care at the right time

- Senior staff reported that their staffing vacancy level was having a negative impact on waiting times for community services. In the past they had used agency staff to specifically help reduce waiting list sizes which had proved effective. In addition this could result in a reduced frequency of visits for 'low risk' patients and rescheduled appointments. However, staff reported that they did not yet feel that these issues were compromising the safety of their patients or the quality of care people received.

Good

Are services responsive to people's needs?

- Team leaders and junior staff told us that the numbers of patients on their case loads were increasing. They said that on a daily basis, due to low staffing levels, they needed to prioritise the patients with the greatest needs and reschedule other patients.
- However, some staff expressed concerns that the changes to shift patterns meant that they would be visiting patients between 7am and 7pm, which was quite early/late to provide routine care. We were told that staff and patients were not consulted on the shift times.

Learning from complaints and concerns

- Senior staff reported that they did not receive many formal complaints. It was the responsibility for the local team leader or head of service to investigate them and the learning would be taken back to local team meetings. It was reported that the majority of complaints tend to be about patient treatment expectations or communications. When a complaint was first received the complainant would usually be telephoned directly as a matter of course to see if the matter could be resolved immediately.
- A record was kept of the complaints that had arrived which confirmed that the majority were about treatment or communications. This log retained details of when complaints arrived and when they were responded to. It was reviewed on a regular basis as part of the service's governance process.
- Between April 2015 and May 2016 the average time to respond to a complaint about the district nursing team was 29 working days and 12 working days for complaints about the learning disabilities team.
- Management staff that we spoke with were aware of the complaints that had been received relating to their service, their outcome and the learning that had come from them. Staff told us that they got feedback on complaints and any lessons learnt from them.
- Patients told us that they knew who to contact if they wanted to make a complaint.

Requires improvement

Are services well-led?

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

Summary

We rated well-led as requires improvement because:

- Whilst there were examples of local leadership, there was limited evidence for any overall strategy for the service from a trust level.
- There were concerns expressed by staff over recent changes to working patterns, duties and rising workloads. These concerns were expressed across several teams and were having a significant effect on staff morale in certain areas.
- Staff in general did not feel connected to the trust as a whole and felt that the community services in general did not receive appropriate focus or consideration on a senior trust level.

However:

- There were numerous local initiatives in place and being planned to improve the quality of the service which were in line with NHS Strategic priorities to further integrate services and achieve efficiencies.
- Service level staff and teams were dedicated to providing high quality, safe, compassionate care for patients, as well as working as a team and helping each other where needed.

Detailed findings

Service vision and strategy

- In numerous local teams and areas we found initiatives that were being trialled and put in place to improve the efficiency of the service and the quality of care which staff were proud of. There was a focus across the service of achieving efficiency savings whilst maintaining quality standards.
- However, often this was coordinated and managed on a team level or at the directorate level. We saw limited evidence of a longer term plan for the service or a definite strategic direction being provided from the senior Trust staff.

Governance, risk management and quality measurement

- Senior staff were positive the governance structure they had in place which they described as "robust". The directorate held a monthly divisional governance meeting.
- The high vacancy rates and increasing demand for services were on the department's risk register. Other items on the community services-wide register included re-tendering of services, not achieving the planned savings and staff access to the new e-learning system.
- Divisional meetings of managers were used to discuss performance and governance data. We saw copies of the minutes of these meetings and items covered included updates on finances, IT provision, workforce engagement and patient feedback.
- In advance of the inspection the service had developed an improvement plan based around the CQC's 'key lines of enquiry'. This included numerous items relating to different aspects of the business including improving staffing levels, improving the implementation of agency inductions, increased use of outcome measures and responding to staff feedback.
- We looked at the results of audits of patient notes from the maximising independence team. Following the first audit an action plan had been put in place to ensure improvements were made.
- Senior staff told us they had a positive relationship with the local clinical commissioning group who they met with on a regular basis.
- The district nursing staff that we spoke with were not clear about the operational impact of their governance information and said that there was no routine escalation of information from management.

Leadership of this service

- Staff provided mixed feedback on the leadership of the service. People were able to describe initiatives they had taken to improve the service which they said that senior staff were supportive of.
- However, some expressed concerns at the rate of response to concerns by senior or Trust level managers

or that they had made improvements 'in spite' of their managers. Most did not reference the senior trust team as being instrumental in the management or development of the service and were more likely to reference local or divisional level managers.

Culture within this service

- Whilst there were positive relations within the district nursing teams, staff reported that there was minimal leadership involvement outside of those teams.
- Individual team members that we spoke with were positive about the work ethic within their teams and were clear that the quality of care they provided to patients was their priority. They described themselves as "cohesive" and "caring" and said that they covered for each other.
- There was unease amongst general staff at the moment over the upcoming re-tendering of therapy services and whether the service was be successful in retaining these contracts. There were increasing pressures on current staffing in terms of reducing costs and increasing activity levels.
- The recent restructure of the service had also had a negative impact and created unrest amongst staff with concerns being expressed over changes to individual job roles and questions over the practicalities of the reorientation of the service around new geographical centres. Other staff said they did not feel valued or recognised by managers.

Public engagement

- The service undertook the Friends and Family Test to get feedback on the quality of the service they were providing.
- The local CCG ran a patient experience group which staff got feedback from.
- The trust had clinical reference groups which looked at the performance of individual teams and there were patient representatives on all of these groups. Team leaders described most of the feedback they received as positive.

Staff engagement

- District nursing staff also expressed concerns about the new shift times that had been "forced" on them and were seen to be incompatible with school times and staff with child care commitments. However, following the inspection, we were informed by the trust, that prior to this change, a consultation with staff did take place.
- Senior staff reported that the high vacancy rate was having an effect on morale with staff under increasing pressure.
- Generally speaking, staff within the division did not feel like they were an integral part of the Trust as a whole. They said that they felt the community divisions did not receive as much attention as the acute divisions with the tone and focus of communications and initiatives often centred on the acute side with little consideration being given to community divisions.

Innovation, improvement and sustainability

- There were several initiatives underway or being planned which were aligned with the NHS strategic priorities of integrating services, achieving efficiencies and expanding the level of community provision to take the pressure off of acute services.
- Senior staff spoke positively of their community MDT teams which featured a full range of professionals including nurses, GPs and therapy staff. They met on a regular basis to discuss the full healthcare needs of patients. Staff told us that this had made improvements to patient outcomes with reduced Accident and Emergency department attendances and acute admission rates and we saw evidence of this.
- The service was working with local GPs to set up 'Enhanced Care Pathways' for patients who frequently attended and used acute services to try and prevent admissions.
- There was a dedicated falls service which was being developed around the physiotherapy department. The aim was to have this service integrated with the maximising independence clinic, the acute accident and emergency department and the orthopaedic and osteopathy services. Working across these services they were aiming to target young and old people who could benefit from ongoing monitoring and earlier intervention. It also included further education services for patients as well as peer support and further sporting or other physical activity sessions in the community run by volunteers.

Requires improvement

Are services well-led?

- There was work underway to integrate the community Learning Disability team with the local Mental Health Trust Learning Disability team so that there would be one point of access for both physical and mental health services for their patients.
- Whilst many junior staff expressed a desire to be involved in service innovation and improvement, they reported that the pressures on their time prohibited them from doing so.