

Central and North West London NHS Foundation Trust

Community health services for adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RV3EE	Trust Headquarters Stephenson House 75 Hampstead Road London		NW1 2PL

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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?

Good 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for community adult services of **good** because:

We directly observed staff treating patients with dignity and respect. All the patients we spoke with told us they had received good and compassionate care. Often telling us staff had been very flexible and had done more than was expected of them. Staff consistently involved patients and their families in their care. We observed staff giving patients detailed information about their treatment and discussing this with them. Staff we spoke with were aware of the importance of gaining patient's consent and had an understanding of the Mental Capacity Act. Additional training was being provided in some areas.

Staff teams received equality and diversity training and consistently reported good access to interpreters. People using the services received information and care in a manner that met their individual needs in terms of their language, culture, religion and disability. Teams told us they had good access to patient equipment which was usually delivered in a timely way.

Leaflets had been given to patients on how to complain and where possible complaints were addressed quickly at a local level. Where formal complaints took place they were addressed thoroughly and staff learnt from the complaints.

Staff knew how to report incidents and there was learning from these events. The organisation was open when things went wrong and would keep the patient informed of the action they were taking. Safeguarding matters were correctly alerted and there was learning where needed.

Medicine management varied between teams depending on local arrangements. In most cases infection control was managed well although this needed improvement in Hillingdon.

There were sufficient staff available to provide services, although this could at times be challenging and required ongoing monitoring. Staff said they had regular supervision, a recent appraisal and felt well supported within teams. We were consistently told that the trust supported and encouraged access to training. Arrangements were being made to monitor the frequency of supervision to ensure a consistent approach. There was good multi-disciplinary working and effective handover and multi-disciplinary team meetings. Staff consistently told us they had good links, and access to, a wide range of other services. Staff said they felt well supported by team leaders and most senior managers. Most staff felt valued and respected by the organisation.

We saw clear referral processes to teams often with duty staff to triage referrals received. Referral and transition process varied across the teams we visited and where there were challenges these were being reviewed.

A range of audits had been completed and improvements made to services in response to the findings. Teams were informed of changes to national guidance and practice had changed as a result of new guidance. There were good examples of innovation and close working with local clinical commissioning groups. We were told these innovations had been well supported by senior managers. The trust annual gem and team awards celebrate such developments.

Record keeping was generally good but needed more work to be of a consistency high standard.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We rated safe as **good** because:

Staff knew how to report incidents and there was learning from these events. The organisation was open when things went wrong and would keep the patient informed of the action they were taking.

Safeguarding matters were correctly alerted and there was learning where needed.

Medicine management varied between teams depending on local arrangements. Staff had received training and followed guidance.

Detailed and comprehensive records were kept although where computer and paper records were used this could result in duplication and a lack of consistency.

In most cases infection control was managed well although this needed improvement in Hillingdon.

There were sufficient staff available to provide services, although this could at times be challenging and required ongoing monitoring.

Good



Are services effective?

We rated effective as **good** because:

Teams were informed of changes to national guidance and practice had changed as a result of new guidance.

A range of audits had been completed and improvements made to services in response to the findings.

Staff said they had regular supervision, a recent appraisal and felt well supported within teams. We were consistently told that the trust supported and encouraged access to training. Arrangements were being made to monitor the frequency of supervision to ensure a consistent approach

There was good multi-disciplinary working and effective handover and multi-disciplinary team meetings. Staff consistently told us they had good links, and access to, a wide range of other services.

We saw clear referral processes to teams often with duty staff to triage referrals received. Referral and transition process varied across the teams we visited and where there were challenges these were being reviewed.

Staff we spoke with were aware of the importance of gaining patient's consent and had an understanding of the Mental Capacity Act. Additional training was being provided in some areas.

Good



Summary of findings

Record keeping was generally good but needs more work to be of a consistently high standard.

Are services caring?

We rated caring as **good** because:

We directly observed staff treating patients with dignity and respect.

All the patients we spoke with told us they had received good and compassionate care. Often telling us staff had been very flexible and had done more than was expected of them.

Staff consistently involved patients and their families in their care. We observed staff giving patients detailed information about their treatment and discussing this with them.

Good



Are services responsive to people's needs?

We rated responsive as **good** because:

Staff teams received equality and diversity training and consistently reported good access to interpreters. People using the services received information and care in a manner that met their individual needs in terms of their language, culture, religion and disability.

Teams worked together to meet peoples individual needs for example in their end of life care.

Teams told us they had good access to patient equipment which was usually delivered in a timely way.

Leaflets had been given to patients on how to complain and where possible complaints were addressed quickly at a local level. Where formal complaints took place they were addressed thoroughly and staff learnt from the complaints.

Good



Are services well-led?

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

Staff were aware of the trust values and told us these resonated with team values and approach.

There was good communication from senior managers and information from the trust was shared at team meetings. Some staff reported the merging of teams and services had been difficult at times and they looked forward to a period of stability.

Staff consistently reported they felt well supported by team leaders and most senior managers. Most staff felt valued and respected by the organisation.

Good



Summary of findings

There were good examples of innovation and close working with local clinical commissioning groups. We were told these innovations had been well supported by senior managers. The trust annual gem and team awards celebrate such developments.

Summary of findings

Information about the service

During the inspection we visited the following teams:

District Nursing Teams at:

Sovereign Medical Centre, Milton Keynes

Red House Surgery, Milton Keynes

Stony Stratford, Milton Keynes

Minet Clinic, Hillingdon

Belmont Medical Centre, Hillingdon

District Nursing services support patients who are housebound by providing nursing care in their own homes and other community settings. Services work in partnership with specialist community nursing and therapy services, patients, carers, general practitioners and social care teams to provide high-quality nursing care and advice. The service offers professional advice, support, teaching and skilled nursing care to enable people to live as independently as possible with an acute or chronic illness/disability who have a nursing need

Rapid Assessment and Intervention Team, Bletchley Hospital

Hillingdon Rapid Response Team, Ickenham Clinic

These teams provide assessment, care planning and therapy to rehabilitate and promote independence in patients' own homes or as close to home as possible. They are one of a range of intermediate care services which provide therapies and rehabilitation in community settings for adults. The team aims to assist patients to remain as independent as possible within their own home, supporting early discharge from hospital and avoiding hospital admission.

Hillingdon Community Rehabilitation Team, Laurel Lodge Clinic

This team provides a community-based, multi-disciplinary therapy service for adult patients who have recently been discharged from hospital following a stroke or fall, or who have been diagnosed with a long-term condition.

Camden Integrated Primary Care Teams at Hunter Street Health Centre and Gospel Oak Health Centre

These teams encompass district nursing care, rehabilitation, self-management and enablement for people in their own homes and other community settings. The multi-disciplinary team is made up predominantly of district and community nurses, occupational therapists and physiotherapists with close links to psychologists and speech and language therapists. The teams work closely with general practitioners.

Camden Neurological and Stroke Service, St Pancras Hospital

This multi-disciplinary team provides a range of rehabilitation services for Camden residents with neurological conditions. The team consists of physiotherapists, occupational therapists, speech and language therapists, clinical neurological psychologists, a dietician and rehabilitation assistants.

Respiratory services, St Pancras Hospital

This team treats and manages diseases of the respiratory system, and provides education and support for patients and other healthcare services. The team includes nurses, physiotherapists, respiratory consultants and psychologists.

Our inspection team

The team that inspected adult community services had seven members and included CQC inspectors, specialist advisers including a therapies manager, district nurse, community matron, specialist nurse and an expert by experience both as a carer and patient.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive pilot 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 23 - 27 February 2015.

During the inspection visit, the inspection team:

- Visited 12 community based teams; four in Milton Keynes, four in Hillingdon and four in Camden

- Spoke with 23 patients who were using the services some face to face and some on the telephone
- Spoke with the 16 managers, deputy managers, team and clinical leaders
- Spoke with 25 other staff members including community nurses, therapists and rehabilitation assistants
- Joined therapy and nursing staff on 24 home visits
- Attended and observed five hand-over meetings and one multi-disciplinary meeting
- Joined a falls group and pulmonary rehabilitation exercise session

We also:

- Looked at 10 treatment records of patients (five on home visits).
- Looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

All patients we spoke with informed us they were very happy with the service they received from nurses and therapists. They used words such as wonderful, brilliant, excellent, knowledgeable, caring, extraordinary, helpful and polite to describe their feelings about services and wanted to emphasise how flexible staff were.

Patients told us they were treated respectfully and with dignity and staff actively involved them in their treatment. They told us staff asked permission before performing any treatment.

Patients gave us good examples of how the treatment they had received had significantly improved their quality of life. They spoke about positive changes in their health and how staff were willing to sort out any problem.

They told us staff arranged equipment for them and this had helped. Two patients told us there had been some problems with equipment they had received but staff had tried to sort this out.

We were told of good communication and liaison between services and how patients' and their carers felt involved in their treatment.

Good practice

- Good partnership working between Hillingdon hospital and the community rehabilitation team had

Summary of findings

highlighted to commissioners bed days could be reduced by providing intensive seven day a week therapy through evidenced based practice. As a result commissioners had invested significantly in the rehabilitation team.

- Camden respiratory and neuro-therapy teams had a range of positive initiatives to ensure vulnerable people had access to good quality and effective care. For example taxis were provided for the patient and carer to attend the pulmonary rehabilitation class. The class included group and individual exercises, education sessions and a question and answer session

with the consultant. Sessions with a nurse, clinical psychologist, dietitian, occupational and physiotherapists were available. British Lung Foundation packs were given to patients and leaflets were available in different languages with access to interpreters if required. Patient feedback had informed the timing of sessions.

The district nurse bag in Milton Keynes had been designed to ensure all the necessary equipment was available to use during each appointment.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve in community health adult teams

- The district nursing staff in Hillingdon should all have with them the essential equipment needed to do their job.

- Where teams are using electronic and paper patient notes the recording should be more consistent. Assessments and the review of assessments should be completed in line with the agreed procedures for the team.
- The district nursing teams in Hillingdon should all maintain high standards of infection control practice.

Central and North West London NHS Foundation
Trust

Community health services for adults

Detailed findings

Name of service (e.g. ward/unit/team)

Name of CQC registered location

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated safe as **good** because:

Staff knew how to report incidents and there was learning from these events. The organisation was open when things went wrong and would keep the patient informed of the action they were taking.

Safeguarding matters were correctly alerted and there was learning where needed.

Medicine management varied between teams depending on local arrangements. Staff had received training and followed guidance.

Detailed and comprehensive records were kept although where computer and paper records were used this could result in duplication and a lack of consistency.

In most cases infection control was managed well although this needed improvement in Hillingdon.

There were sufficient staff available to provide services, although this could at times be challenging and required ongoing monitoring.

disseminated to all staff and necessary changes in practice put in place. Incidents in Hillingdon and Camden were also reported on the incident reporting system.

- All staff we spoke with consistently told us they were aware of how to report incidents and were confident of how to do this correctly. They explained the type of incidents they would report. Staff told us incidents such as grade two pressure ulcers, medicine issues, near misses, poor discharge from hospital and equipment not delivered as expected would be reported. We saw an example of an incident report made on 17th February 2015 and saw this report was detailed and included action taken at the time.
- District nursing teams in Milton Keynes reported a total of 51 incidents in January 2015 of which 23 were pressure ulcers. Other incidents included medicine errors, violence and poor discharge from hospital.
- As a consequence of a root cause analysis undertaken on an incident that occurred in the Hillingdon district nursing team strict guidelines had been developed for staff to follow when documenting pressure ulcers.
- Learning from incidents was discussed in a range of meetings that varied from team to team. Structured processes were in place for cascading information. For example in Milton Keynes there was a monthly leadership meeting attended by all district nurses, service manager and district nurse manager, a bi-monthly meeting attended by all service leads and monthly local team meetings. Minutes of meetings were shared with staff. The tissue viability team would meet with the relevant nursing team to discuss outcomes of the investigation and the action plan.
- In Hillingdon a team manager told us they attended the monthly adult services team leaders meeting chaired by the head of adult services in Hillingdon. Incidents were discussed at this meeting including significant incidents that had occurred in other boroughs. Any incidents and associated learning were shared within the team at the monthly staff meeting. Community nursing teams had similar structured meetings in place.
- Camden integrated primary care teams had a weekly governance meeting where learning was shared. We saw the notes of a recent meeting and saw findings from an inquest in another locality had been shared and this

Our findings

Reporting incidents and learning from when things go wrong

- In Milton Keynes incidents were completed on line using their incident reporting system which was a different system to the rest of the trust. The system being used in other parts of the trust was being extended to Milton Keynes. Some staff told us they had already received training in using the new system. We were told this separate system meant there were some limitations on feedback and sharing of learning from incidents from other trust locations. There were processes in place for sharing and learning from incidents in Milton Keynes. For example incidents that occurred in other areas would be emailed to the team and discussed at handover meetings. An example was given of a recent incident in the trust. Learning from the incident was

Are services safe?

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had proved a useful learning process. We were given an example of learning from an inquest that highlighted every team should have spare suction equipment and this had been provided.

- The rapid assessment and intervention team in Milton Keynes gave us examples of how they had reflected and learned from incidents. A recent investigation of a reported pressure ulcer was undertaken by the manager and tissue viability nurse and all team members had been involved. The outcome of this investigation led to all staff receiving in house training and all disciplines in the team now used body maps. Nurses went on home visits to advise on the use of body maps and Waterlow (pressure ulcer and prevention tool) assessments. Team members did joint visits to learn skills that could be shared.
- Staff from the district nursing team based at the Sovereign medical centre in Milton Keynes told us a high level of pressure ulcer incidents had led to changes in practice. This included risk scoring every patient using the Waterlow assessment. Information leaflets were given to patients on pressure ulcer prevention and pressure ulcer checks were part of every routine visit. If patients declined equipment or advice this was recorded. Nurses constantly educated patients and their families and reminded people to use pressure relieving equipment. We were told health care assistants would alert the nurses when any concerns were identified. The team received very good support and advice from tissue viability team.
- Following any reported incident the manager from the district nursing team based at the Sovereign medical centre in Milton Keynes completed a root cause analysis that was sent to the clinical governance department. Pressure injuries grade two and above would also be investigated by the tissue viability team. Serious incidents were discussed at the community nursing serious incident panel which met every two weeks. We saw minutes of the meeting on 2nd and 16th February and noted these referred to duty of candour and actions to be taken or followed up.
- Safety thermometer information was recorded and received monthly and this included numbers of patients with deep vein thrombosis, pressure ulcers, urinary tract infections and falls. Reducing avoidable pressure ulcers in Milton Keynes had been a target in CNWL's quality account 2013-2014 and this had been achieved

- Staff that had been involved in serious incident investigation told us they felt the process was focussed on learning rather than blame. Although this was a difficult process the learning from the incident had been invaluable.

Duty of Candour

- Staff in all teams we spoke with told us the organisation was open when things went wrong. They explained the patient would be involved in the investigation, informed of the outcome and the team would let people know when mistakes had been made. The patient was offered information in writing or a personal visit. One member of staff said incident reports were given to patients and told us it felt like "sharing of information with the patient was becoming embedded in the culture."
- We saw documentation for the investigation of a grade three pressure ulcer. The information included a letter to the patient apologising for the incident and outlining the investigation that would be undertaken and inviting the patient to contact the manager if they had any concerns or information. Actions had been identified as a result of the investigation and recommendations included informing the patient of the outcome in line with the organisations duty of candour.
- We saw the serious incident reporting flow chart and this clearly stated the need for communication with the patient and carers and the importance of being open.

Safeguarding

- Staff we spoke with told us they had undertaken mandatory training in safeguarding adults and this was up to date. 85% to 90% of community nursing teams in Milton Keynes had completed basic safeguarding training. The trust's safeguarding adults board report for the year 2013-14 gave details of staff survey that had been undertaken and this identified 76% of all staff had completed safeguarding training in the past 12 months, and 93% of staff were aware of who to contact if they had to make an alert.
- Staff gave us examples of safeguarding alerts. For example an alert made in 2014 had resulted in a prosecution. The experience of attending court to give evidence had been fed back to the team as a learning experience. Another member of staff told us they made an alert due to the person becoming unkempt and evidence of burnt food in the home as there were

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concerns over the person's safety. The alert was followed up but no further action was required at the time. Another example we were given was an alert being made because there was no indication on the medicine administration record that medicines had been given by the paid carer.

- In Hillingdon two alerts had been made in January 2015. Alerts were made directly to the local authority safeguarding team and the trust safeguarding lead was informed of the alert being made. There were good links between the CNWL and local authority leads. Work with care homes had generated a lot of alerts and this had led to close working with local inspectors from the care quality commission.
- All staff we spoke with told us they had good access to the trust safeguarding lead and had felt supported through the process when they had made an alert.
- In Milton Keynes one team told us safeguarding concerns were taken to the district nurse and referral made to the social care safeguarding team and the safeguarding team for the trust was also informed. They told us there was a bi-monthly meeting with GP's where all safeguarding alerts were discussed and actions agreed.
- A team leader, who was a representative on the local adult safeguarding committee, reported the trust took safeguarding very seriously.

Medicines Management

- Community nursing teams in Milton Keynes appeared to administer a high proportion of oral medicines and on occasions medicines would also be collected from the chemist. This duty would not usually be such a large feature of the district nurses role and some teams felt this added to their high workload. One nurse told us medicine administration at the weekends could be problematic due to high volumes of patients requiring this.
- One team member told us they were not a non-medical prescriber but had completed "transcribing training". This was used on the patient rehabilitation unit if two forms of evidence were available to transcribe on to medicine administration records so carers could administer medicines. Another Band five nurse told us they completed medicine administration record charts for carers in line with the trust transcribing policy using two pieces of evidence.
- Another district nurse from the team based at the Sovereign medical centre in Milton Keynes told us that patients usually supplied locked boxes for medicines in their homes.
- Camden integrated primary care community nursing staff administered oral medicines and medicines administration was included in the referral criteria agreed with the clinical commissioning group. We were told this was an historical issue and a lot of work had been done with the local authority and GP's to change this practice. It was becoming possible to discharge some patients and the team were working with patients to do this sensitively. We were given examples of learning by the Camden integrated primary care team that had led to changes in practice, for example a locked box had been acquired for a patient who had lost medicines. The pharmacist had visited the team to facilitate medicine management education. Clear guidelines were in place for staff transcribing medicines and band six staff and above could transcribe for syringe drivers; band six and seven for controlled drugs; band five for oral medicines.
- Community nurses in Camden integrated primary care teams told us that whilst GP's can prescribe dressings the nurse prescribers were commissioned to prescribe from the formulated list but dressings not on the list that required consent from the tissue viability team. We were told this process had reduced duplication of ordering and reduced delays for delivery.
- We were told community nursing teams in Hillingdon did not usually administer oral medicines. On a home visit we saw the insulin recording sheet was comprehensive and documentation was re-written approximately every six weeks. One team reported they would not usually carry medicines unless the health of a patient who was receiving palliative care deteriorated and medicines were required urgently for symptom control.
- The majority of team members had completed medicines training within the last three years as expected by the trust.
- On two home visits we saw the prescription sheet had been signed by the GP and medicine dose, expiry and site of injection were recorded on the record of visits sheet. We observed the nurse washed their hands prior

Are services safe?

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to administering oral medicines and referred to the prescription sheet as signed by the GP. The nurse told us the patient was living with dementia and would not take their medicines if the nurse did not call.

- On a home visit in Hillingdon we saw the person's evening medicines had already been signed for but the family were not able to say whether another nurse had visited during the afternoon. The log in sheet had not been signed and therefore the nurse gave the medicine. This incident was reported and an initial investigation was started.

Safety of Equipment

- Each community nurse in Milton Keynes had a nursing bag that contained all their equipment. This had been developed by two district nursing students in response to a patient survey that highlighted patient's preferred nurses to come to the house fully equipped and not have to return to their car for a specific piece of equipment. The bags had a list of contents to ensure all the equipment was in place.
- On a home visit in Hillingdon we observed the nursing bag was inadequate. The bag contained dressings possibly required but the nurse needed to carry a box of gloves separately as there was insufficient room in the bag. The nurse did not have a blood pressure machine or thermometer and lacked equipment to undertake necessary assessments. One nurse told us it would be really be useful to be issued with a professional bag and the appropriate equipment to undertake all necessary assessments.
- In Milton Keynes we were told each nursing team had scales, digital camera, two syringe drivers, and bladder scanners shared with the continence team.
- We observed some community nursing teams worked in offices with limited space for working and storage. The rapid access team in Hillingdon worked from a small building inappropriate for their needs. Patient status boards were propped up adjacent to windows due to lack of wall space. There was insufficient space and limited access to computer terminals. Two district nursing teams we visited also had limited space to work from.

Records and Management

- There were variations between teams regarding the use of the computer clinical record system and paper based records. Generally therapy teams used only computer

records whilst nursing teams used paper notes that were kept in the patient's home. Some information would be entered into the electronic system. A new computer based system was due to be introduced that would be compatible with GP systems.

- In Milton Keynes there were two patient record systems being used which was very challenging for the staff.

Cleanliness, infection control and hygiene

- Staff had attended infection control training and mandatory training records showed staff were up to date with this training.
- Staff had the necessary personal protective equipment including gloves, hand gel, aprons, paper towels, floor liners, etc. Every patient was treated as an infection risk and therefore precautions taken. Equipment was cleaned between visiting patients and we saw a log was kept of equipment cleaned. Staff were aware of bare below elbow requirements. A team leader in Hillingdon told us an incident alert would be used if there was a particular infection risk.
- Hand hygiene audits were completed as part of the essential steps audit and we saw the collated results of this for the Milton Keynes community nursing service for February 2014 which showed 100% compliance.
- We were told there were good links and support from the infection control team. There were processes in place for managing clinical specimens and waste management and staff had sharps containers.
- We observed good infection control and hygiene measures being followed on home visits. We observed nurses thoroughly washing their hands and using protective apron and gloves when offering treatment and therapists following hand hygiene procedures and cleaning equipment after use.
- On a home visit in Hillingdon we observed good hand washing and use of gloves and apron but the nurse had left their cardigan on although sleeves were rolled up. On another home visit we observed practice that could have led to contamination and cross infection. On two other visits with a different nurse we saw the dressing pack being opened whilst the nurse wore a fleece (although sleeves were rolled up). Dressings were undertaken with the fleece on and apron over the fleece. It would be expected that the outer layer of clothing would be removed to reduce the infection control risk. Hand gel was used prior to the treatment

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and the nurse washed their hands after. On five home visits in Hillingdon with another nurse we again observed the same poor infection control practice with the outer layer of clothing not being removed.

Mandatory Training

- Staff told us their mandatory training was up to date and they were allocated time to complete this training at work. Community nursing teams in Milton Keynes had achieved 85% to 90% of staff being up to date. Managers we spoke with recognised this needed to be improved. An integrated primary care team in Camden reported 98% of staff up to date with training.
- Staff we spoke with told us the computer system alerted staff when mandatory training needed to be updated. We were told staff had a responsibility to book on necessary training. Mandatory training was discussed at staff supervision. We were told there were no difficulties in accessing mandatory training or being released from duties.

Assessing and responding to patient risk

- We saw risk assessments had been completed and these had been scanned into the computer system. Risk assessments included environmental risk.
- We were told on the first visit a domiciliary risk assessment was completed. This was a broad risk assessment that included patient and staff risk. This document was kept at the office (rather than the person's home) to ensure staff had necessary access. Any changes within the person's home would trigger an update to the risk assessment. Other risk assessments completed included Waterlow, MUST (malnutrition universal screening tool used to identify people that may be at risk of malnutrition), moving and handling and falls risk assessments.
- On a home visit in Hillingdon we saw measurements of wounds being taken and digital images made as a point of reference.
- The Camden respiratory team had a risk register for patients who were not on the "domiciliary care" pathway, who were isolated and with a poor support network. This was to alert the team the patient may require more support.

Staffing levels and caseload

- Staff we spoke with in a therapy team in Milton Keynes told us of concerns about safe staffing levels that had

been highlighted on the risk register. The team reported a year on year increase in referrals since 2012. Winter pressure money had been allocated to employ locum occupational therapists to work in the accident and emergency department to support discharge. It was not possible to use many locum or agency staff due to the complex nature of the work. We were told the pressure on staff to see people referred did sometimes result in reduction in morale. A team member explained that the fluctuating referrals to the service sometimes resulted in urgent care being prioritised and patients being supported with their rehabilitation not receiving the input as planned. The therapy team was piloting the use of the electronic staff rota with an expected roll out date of 1st April 2015. The system monitored safe staffing levels. At the time of the inspection the team used a paper rota and staffing levels were reported by teleconference to the intermediate care team manager. When staffing levels were low visits had to be prioritised.

- Community nursing staff in Milton Keynes told us team leaders reported weekly on staffing levels using a risk rated recording system. The teams also had a workload priority system that prioritises patients that could be seen in four days or more, patients to be seen in one to three days and patients that must be seen on the allocated day. When allocating staff their skills, time needed to spend with the patient and complexity of need were considered. We were told patient preferences for male or female staff could be accommodated. Community staff we spoke with told us they felt staffing was about right for the work they had to do but it was difficult when they had to cover vacancies and sickness.
- In Hillingdon a community nursing team said an external organisation had looked at working practices across the borough and made recommendations on how more time could be focussed on patients. As a result community nursing assistant posts had been introduced in 2014 to provide support with administrative tasks. At the time of our inspection a band five community nursing post had been frozen for five to six months. A district nurse told us staffing was adequate when everyone was working but sickness and annual leave did affect the team's work.
- A manager in the integrated primary care teams in Camden told us a review had been undertaken of the community nursing establishment and it had been identified that they were 22 nursing staff short across three teams. A bid for additional staff had been made to

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

the clinical commissioning group. A district nurse transformation board had been set up and as a consequence a number changes to processes and criteria for referral to the teams had changed. For example the team was commissioned only to see non ambulant patients. Oral medicines had traditionally been administered by community nurses but work with the local authority and continuing care lead had begun to change this practice. There had also been the introduction of safe staffing tools to monitor staffing levels and co-ordinate support from other teams when needed. When agency staff had to be used this would be during the week and permanent staff would work at weekends to ensure safe and consistent care. It had been difficult to recruit band seven nurse vacancies to the integrated primary care team. Permission had been given to over recruit at band five and six and identify staff with talent to develop leadership and clinical skills to achieve promotion within the team.

Managing anticipated risks

- We saw the community nursing service capacity was listed on the service risk register. Actions were in place to minimise risks of poor quality care to patients. The risk register also included poor discharge from hospital due to poor communication, maladministration of medicines and use of bed rails.
- Lone working was identified as a risk on a service risk register and we saw actions had been put into place to minimise this risk. Actions included transfer of care forms identifying lone worker risk, buddying systems, using the alert system in the patient electronic record system to report risk and a tool had been developed to record lone working start and finishing times. It was expected any incidents would be reported. Personal safety devices linked to a management centre were available for high risk patients.
- One team we visited explained the plans they had in place for continuing to provide care in inclement weather. Nurses would visit patients in their location with patient priorities being identified.

Are services effective?

Good 

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 of findings

We rated effective as **good** because:

Teams were informed of changes to national guidance and practice had changed as a result of new guidance.

A range of audits had been completed and improvements made to services in response to the findings.

Staff said they had regular supervision, a recent appraisal and felt well supported within teams. We were consistently told that the trust supported and encouraged access to training. Arrangements were being made to monitor the frequency of supervision to ensure a consistent approach

There was good multi-disciplinary working and effective handover and multi-disciplinary team meetings. Staff consistently told us they had good links, and access to, a wide range of other services.

We saw clear referral processes to teams often with duty staff to triage referrals received. Referral and transition process varied across the teams we visited and where there were challenges these were being reviewed.

Staff we spoke with were aware of the importance of gaining patient's consent and had an understanding of the Mental Capacity Act. Additional training was being provided in some areas.

Record keeping was generally good but needs more work to be of a consistently high standard.

to changes in practice including staff training. All patients referred to the service who were over 65 years had a falls risk assessment. This was now a key performance indicator.

- We observed at a community nurse handover meeting evidence based pressure ulcer treatment was followed. Staff worked to a wound care formulary. Staff told us they had received training from the tissue viability team.

Use of technology and telemedicine

- A community nursing team in Milton Keynes reported the use of telehealth had reduced acute exacerbation of illness and improved access to timely treatment.

Approach to monitoring quality and people's outcomes

- There were a wide range of clinical audits being used throughout the community health services adult teams.
 - The rapid assessment and intervention team in Milton Keynes and Hillingdon community therapy team had completed the annual national intermediate care audit.
 - Staff in the rapid assessment and intervention team told us lessons learnt from a falls audit led to therapy staff in the team checking the patient's blood pressure as part of their routine assessments. The team in Hillingdon reviewed action taken for patients experiencing recurrent admissions to accident and emergency. They worked with consultants to include a prompt in the letter to the GP reminding them to refer the patient to urology where needed.
 - An annual audit of note keeping was undertaken across teams. We saw an audit of district nursing care records in Milton Keynes looking at what information was recorded and also the quality of initial assessments, clinical information and on-going care and record keeping. We saw detailed recommendations made as a result of the audit with time scales for achieving improvements.
 - In Milton Keynes we were told a range of audits were regularly undertaken including, essence of care, infection control, an annual patient records audit, a monthly safety thermometer and falls care bundle.
 - A team in Hillingdon told us a spot check of a random selection of notes was undertaken monthly and six monthly and one of these checks was in the process of being collated and an action plan being developed.
- Chronic obstructive pulmonary disease (COPD)** and venous leg ulcer care bundles had been implemented

Our findings

Evidence based care and treatment

- Policies and guidance used by staff reflected guidance from the National Institute for Health and Care Excellence (NICE) and other professional bodies.
- In Milton Keynes there was a NICE lead who informed the team of changes to guidance. The Hillingdon professional advisory group reviewed all NICE guidance and they would review this to identify if any practice needed to change. We were given an example of how new falls guidance for people with osteoarthritis had led

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and formed part of the outcome measure to reduce admissions to hospital. We saw a monthly catheter care audit was undertaken by a community nursing team in Hillingdon.

- Camden respiratory team had just started a national pulmonary rehabilitation audit that was to run over 12 months to compare teams across the country.
- A hand washing audit was completed across all teams every three months and this was part of the essential steps audit.
- The teams also used a range of outcome measures. For example the therapy team in Hillingdon used the Barthel index which measured performance in activities of daily living to measure patient outcomes. There were also other measures of mobility and falls.
- The respiratory team in Camden used a range of outcome measures including a tool where patients self-rated their health. They also measured their performance using key performance indicators including number of patients where an admission to hospital had been avoided.

Competent staff

- Three new staff reported good induction with the opportunity to shadow experienced colleagues when first joining the team.
- All staff we spoke with consistently told us they had good access to training and this was supported by the trust. For example in Hillingdon we were informed irrespective of staff grade access to training was encouraged. The attendance of two physiotherapy technicians on the positive stability instructor's course was given as an example of this investment in staff. Another example was of a team member undertaking further training in long term conditions at master's level.
- Staff received specialist training to support them do their jobs. For example in the Milton Keynes the rapid assessment and intervention team members had received training in monitoring vital signs, pressure ulcers, using the **malnutrition universal screening tool** (MUST) and venepuncture procedures.
- Staff reported appraisals were up to date and these had been meaningful and useful leading to the identification of training needs. Appraisal recording had been changed recently and this was felt to be an improvement. The appraisal included a personal development plan.

- All staff we spoke with were positive about the support they received and told us they received regular supervision. Frequency of supervision and type of supervision varied between teams. For example team members in the Milton Keynes rapid assessment and intervention team told us they received formal management supervision every six to eight weeks and informal supervision was always available. There was a monthly team meeting. There were also meetings for specific professionals to support clinical supervision. Some teams also provided opportunities for reflective practice.
- Community nurse managers in Milton Keynes told us they recognised monitoring of supervision was weak and an area for improvement. Plans were in place to work on this and two locality managers have been designated to address this issue. It was expected supervision will link to appraisals.
- Staff sickness levels varied across community teams and processes were in place and used to address long term sickness. The teams generally had levels of staff sickness below 4%. Where the percentage was higher it was in small teams where one person's ill health had a greater impact on the overall percentage.
- Concerns over performance issues such as inadequate paperwork or care would initially be monitored through supervision. This could result in increased supervision, mentoring and possibly joint visits to observe the member of staff working with patients. The human resource department was available for support if more formal processes were required.

Multi-disciplinary working and co-ordination of care pathways

- The handover meeting of the rapid assessment and intervention team in Milton Keynes showed good communication between all team members, the effective prioritisation of work, discharge planning and discussions of patients with complex needs. Staff respected each other's skills and felt well supported within the team. Referrals to other teams such as the stroke team and social services were made in a timely way.
- We joined a community nurse handover meeting in Hillingdon and noted discussion of caseload and issues relating to particular patients. Team discussion showed

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there was a good multi-disciplinary approach with the involvement of relatives and carers. A range of issues were considered including capacity and the persons needs in terms of their culture or religion.

- At the nursing team handover meeting in Camden all patients were reviewed and any concerns discussed. Team members gave good clear feedback to the district nurse on the morning visits they had completed. Clarification was sought and details of follow up visits and treatment confirmed. We observed team members had a very good knowledge of their patients, the meeting was well organised and the team had a positive culture of caring.
- Staff we spoke with consistently reported good links with other teams and gave examples of collaborative working. One district nurse team told us there was good support between teams with joint visits possible with specialists from other teams including the palliative care team.
- The Milton Keynes rapid assessment and intervention team told us they had good access to social workers who were based in the same building and also the duty social worker.
- A district nursing team reported the GP practice had multi-disciplinary gold standard meeting and these now included community matrons.
- The Camden neuro-therapy team have a 'neuro navigator' whose role it was to facilitate the transfer of patients between services to best meet the patient's individual needs. Carers and families were an integral part of the process and had the contact details of the 'neuro-navigator'.

Referral, transfer, discharge and transition

- Each team had different arrangements for receiving and responding to referrals. For example the rapid assessment and intervention team in Milton Keynes had a duty person to respond to a GP hotline. Referrals were triaged and the most appropriate team member undertook the initial assessment.
- The Camden integrated primary care team managers told us there was an open referral process including self-referrals with a separate pathway for nurses and therapists in the team. Referrals for all integrated primary care services went to a central access point at St Pancras and were triaged by the team there. Patients were then allocated on a geographical basis to the most appropriate team.

- The Camden integrated primary care team said there was a clear pathway for discharge from hospital. Generally this would involve referral to the Camden rapid access team (which worked closely with care link the reablement team) and their interventions would usually last five days. Referral could then be made to the integrated primary care team which offered interventions for around six weeks although we were told this could be flexible around patient need. If the patient required an on-going care package social services would be contacted two weeks prior to the expected discharge.
- We saw a risk of poorly managed discharges from Milton Keynes hospital was on the service risk register. A single point of referral had been introduced for people being discharged from the hospital. The register highlighted the need for regular communication between relevant people and monitoring of incidents. We were told new locality managers' responsibilities included a "discharge coordinator role" to improve discharges.

Availability of information

- Most notes we reviewed had assessments comprehensively completed and the evaluation of care plans were documented in the clinical progress notes. Progress notes including telephone contacts were completed. Letters had been sent to the GP.
- We looked at a set of community nursing notes for a team in Hillingdon. We saw the paper notes and electronic notes were not consistent with varying amounts of information inconsistently recorded in each system. We saw paper notes were not fully completed, for example dates on wound assessments were not always entered and syringe driver checklists were not always dated. Communication sheets we reviewed included entries in pencil and blue ink.
- On seven community nurse home visits in Hillingdon we found a few patients had not had all the assessments completed such as MUST. A few patients had not had their assessments reviewed for example a review of a manual handling assessment usually completed every three months was a month overdue.

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Consent

- In some teams we heard that all staff had received training in the Mental Capacity Act (MCA) and in others we heard that more training was being developed and provided. Mental capacity leads were also available.
- Generally staff we spoke with understood the key principles of the MCA. In records we saw examples of capacity being assessed and where needed best interest decisions being taken in consultation with the person's family, GP and other significant people.
- We observed nursing staff asking for patients consent prior to offering treatment.

Are services caring?

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

Summary of findings

We rated caring as **good** because:

We directly observed staff treating patients with dignity and respect.

All the patients we spoke with told us they had received good and compassionate care. Often telling us staff had been very flexible and had done more than was expected of them.

Staff consistently involved patients and their families in their care. We observed staff giving patients detailed information about their treatment and discussing this with them.

Our findings

Dignity, respect and compassionate care

- On home visits we saw staff treating patients with a caring and respectful manner. Patients and their carers also told us that the staff were professional and helpful. We were told by one patient's partner they could not praise the team enough for what they had done.
- The times of patient's appointments tried to fit in with the individual needs of each person and their carers.
- During the home visits and when attending groups we saw staff taking the time to recognise peoples individual needs and supporting them in a sensitive manner with appropriate communication.

Patient understanding and involvement

- Patients were fully involved in their care and decision making and this was recorded in the notes.
- There were examples of useful information being provided for people to help them understand their condition such as information about patient falls.
- Community nursing patient notes were kept in the person's home. Contact numbers for day, twilight and night teams were evident. The nurses reassured the patients about contacting the team if they needed to.
- Patient's signed their care plans to confirm their agreement. The care plans reflected the individual needs of the patient and a section of the plan was for

the patient's expectations of care to be recorded. Family carers would be encouraged to be involved as appropriate and would be asked to stay through the assessment process.

- Camden integrated primary care team told us shared goals with the patient were identified and this process began with the initial screening process which considered the patient's motivation for treatment. We reviewed one set of notes and saw good documentation of involvement of family and need for interpreter. A falls exercise booklet had been translated for the patient and a shared goal had been identified with the patient. It was noted the patient was unable to sign the document and the reason why.
- The trust was using the friends and family test. In Milton Keynes the clerk contacted five patients a month for each district nurse team to complete the friends and family test which resulted in 20-50 responses each month. We saw the summary report for Milton Keynes community health services quarter three 2014 – 2015 friends and family survey which showed 30% of patients were extremely likely to recommend the service to friends and family and 70% were likely.
- Hillingdon community rehabilitation team also contacted people by telephone and received a report on the outcome. A member of the Camden IPCT told us the friends and family test information was included in the patient welcome pack all patients received at the beginning of their treatment. In Camden neuro-therapy team the patient satisfaction survey was available in different languages and a questionnaire was given on discharge.

Emotional support

- On a home visit we observed encouraging, sensitive and supportive attitude to the patient and family carers. The patient was shown how to use equipment and the family reminded to contact the team if there were any negative changes in the patient's health.
- Community nurses told us emotional support was given and the team was available for support including signposting to other services when needed.

Promotion of self-care

- There were many examples of care professionals supporting people to make progress with their health and personal skills to become more independent. This was reflected in peoples individual care plans.

Are services responsive to people's needs?

Good 

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

Summary of findings

We rated responsive as **good** because:

Staff teams received equality and diversity training and consistently reported good access to interpreters. People using the services received information and care in a manner that met their individual needs in terms of their language, culture, religion and disability.

Teams worked together to meet people's individual needs for example in their end of life care.

Teams told us they had good access to patient equipment which was usually delivered in a timely way.

Leaflets had been given to patients on how to complain and where possible complaints were addressed quickly at a local level. Where formal complaints took place they were addressed thoroughly and staff learnt from the complaints.

Our findings

Planning and delivering services which meet people's needs

- Some teams told us they could accommodate patient preferences for male or female staff.

Equality and diversity

- Staff had completed the mandatory equality and diversity training. They made use of interpreters to help with communication. A range of information was available in different languages and formats.
- Teams were also very diverse and where appropriate staff were allocated to patients where they reflected their individual needs such as speaking the same language.

Meeting the needs of people in vulnerable circumstances

- Community nurses worked closely with local palliative care services to support people with their end of life care.
- In Milton Keynes we saw a draft booklet for patients with guidance on making an advance care plan. This had

been developed in partnership between the local hospice, hospital and community staff and a cancer group. This was due to be implemented in May 2015 which would help to ensure a coordinated approach.

- We heard examples of how services raised awareness in the wider community. For example the Camden respiratory services went to screen and diagnose people with possible respiratory problems, for example going to supermarkets, GP surgeries and events to undertake tests. The number of patients screened between January 2013 and September 2014 was 1229; 50 referrals were made for further screening and 133 new diagnosis made. We were told screening had also occurred in mental health in-patient wards and hostels for homeless people. We were told clinical research from this work was presented to the American Thoracic Society in 2014.

Access to the right care at the right time

- Different teams had arrangements in place to ensure patients received the care they needed in a timely manner. This involved systems to receive and prioritise referrals.
- The Milton Keynes rapid assessment and intervention team had a duty team member who triaged referrals using a 'frailty scale'. Response times were two hours for urgent referrals with routine first contact within seventy two hours either face to face or by telephone. Response times were audited and were mostly met. The rapid response team in Hillingdon had trialled team members working in accident and emergency until 10pm. The outcome was that staff present during normal working hours was sufficient.
- Teams told us there was good access to patient equipment such as pressure relieving equipment and the delivery of equipment was prompt and timely. Camden integrated primary care team had on-line ordering and a "prescription model" which meant the patient or family member could collect equipment from the nearest chemist. Any patient with limited mobility would have equipment delivered.
- In Hillingdon it was reported problems existed with delivery of fresh dressings with a lead time of three weeks. The district nursing team were keeping detailed records of orders and deliveries to monitor and address this issue.

Are services responsive to people's needs?

Good 

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

Complaints handling (for this service) and learning from feedback

- All the teams we visited said they tried to respond to complaints locally in the first instance. One team explained on the initial assessment visit patients were given a complaint information leaflet. We were given the example of a recent complaint that had been addressed quickly by sending a senior team member to resolve the

situation. If the situation could not be resolved at this level the patient would be advised to make a formal complaint. Support was available from the patient advice and liaison service if this was required.

- We saw letters of response to complainants that demonstrated extensive investigations had been completed and the patient had been informed of the outcome.
- Team learning from complaints was shared at staff meetings.

Are services well-led?

Good 

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 of findings

Staff were aware of the trust values and told us these resonated with team values and approach.

There was good communication from senior managers and information from the trust was shared at team meetings. Some staff reported the merging of teams and services had been difficult at times and they looked forward to a period of stability.

Staff consistently reported they felt well supported by team leaders and most senior managers. Most staff felt valued and respected by the organisation.

There were good examples of innovation and close working with local clinical commissioning groups. We were told these innovations had been well supported by senior managers. The trust annual gem and team awards celebrate such developments.

Our findings

Service and vision strategy

- Staff we spoke with in every team were aware of the trust vision and values and felt they were consistent with theirs and the teams' values. Staff told us they received regular information from the senior managers by email and blogs and felt connected to the trust. A community nursing team reported the chief executive had visited the team base.
- Trust wide information was shared at the leadership meetings attended by team leaders who cascaded the information to the staff team. Quarterly district nurse meetings were also used to discuss trust wide issues.
- One team leader told us they felt the mental health services were the predominant identity of the trust and community health services was minimalized.
- The manager of Hillingdon community rehabilitation team spoke of looking to develop integrated primary care teams as had been done in Camden. It was planned from April onwards to bring occupational and physiotherapy teams in physical and mental health services together as an integrated service.

Governance, risk management and quality measurement

- Whilst the information available to teams varied, this was being used to monitor and improve services. Teams had access to a range of monthly and quarterly reports.
- Teams were monitoring their key performance indicators where they were available. This enabled them to see how long it took from when patients were referred to when they were assessed and then how long to receive treatment.
- Team managers said they attended meetings where relevant information about incidents, complaints, targets, staffing, policy changes was shared and was then cascaded to the teams.

Leadership of this service

- All staff we spoke with told us they felt well supported by team leaders and local managers. Staff consistently told us they felt their manager was approachable and the manager's door was always open. They had received positive feedback on their work.
- A few staff said they had not had contact with senior managers and felt they did not always know what was happening on the 'front line'. They also did not feel well informed about the changes that were happening in the trust.

Culture within this service

- Staff said they found the culture of the organisation open and transparent.
- They felt able to raise concerns but knew how to access whistle blowing procedures if needed.

Public and staff engagement

- Patients and carers were regularly asked to give feedback through surveys. The results of these were used to look at local services.
- A recently employed member of staff told us a whole section of the induction training covered whistleblowing and the chief executive emphasised the importance of sharing any concerns staff may have and reassured staff they could go directly to her if necessary.
- Staff felt engaged and able to give feedback through supervisions, team meetings and staff surveys. Staff in

Are services well-led?

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Milton Keynes reported the merger of Milton Keynes with CNWL had been difficult due to changes to policies and protocols that had to be accommodated and that this was still an ongoing process.

Innovation, improvement and sustainability

- District nurses in Milton Keynes were proud of the work they had done with the out-patient parenteral anti-microbial therapy provision (OPAT) which was set up by the district nursing service to work alongside the team in Milton Keynes hospital. This enabled IV antibiotics to be given which helped to keep patients out of hospital. This involved in depth training for district nurses which had to be passed at 100% and was good for district nursing skills.
- The development of the 'district nursing bag' in Milton Keynes had been recognised at the trusts annual gem awards. The bag was now being used by all district nursing teams and phlebotomists in the locality.
- The team manager of Hillingdon community rehabilitation team told us of work they had undertaken in partnership with Hillingdon hospital. A project had been established to demonstrate that intensive community rehabilitation seven days a week could reduce bed days for people admitted to hospital following a fall. The project ran from April 2013 for one year and showed on average two bed days per patient could be saved. Over the year of the project 295 patients were discharged to the community rehabilitation team. Presentations were made to GP's and commissioners and as a result the team received significant funding to increase the size of the team by 50%. As a consequence of this week the team were nominated for the trust annual gem and team awards and came runner up in 2014. Staff we spoke with told us they were proud to have been part of this work.
- In Hillingdon we were told a new post had been created for a clinical lead to work across the three divisions with the three directors to standardise care and share good practice between district nursing teams. Work was also being undertaken with the clinical commissioning group to reduce admission to accident and emergency departments from care homes and also support to patient's to end their life in their preferred place of care.
- Integrated primary care teams in Camden were working on a business case to present to the clinical commissioning group regarding working with housebound patients with musculoskeletal conditions. This was in response to the clinical commissioning group wanting to have a better coordinated service across the borough for patients living with these conditions