

Guy's and St Thomas' NHS Foundation Trust

RJ1

Community health services for adults

Quality Report

Trust Office, 4th Floor Gassiot House
St Thomas' Hospital, Westminster Bridge Road
London
SE1 7EH
Tel: 020 7188 7188
Website: www.guysandstthomas.nhs.uk

Date of inspection visit: To Be Confirmed
Date of publication: 24/03/2016

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)
RJ1X6	Guy's & St Thomas' NHS Foundation Trust Community Services Community health services for adults	Akerman Health Centre	SW9 6SF
RJ1X6	Guy's & St Thomas' NHS Foundation Trust Community Services Community health services for adults	Townley Road Clinic	SW22 8SW
RJ1X6	Guy's & St Thomas' NHS Foundation Trust Community Services Community health services for adults	Dulwich Community Hospital	SE22 8PT
RJ1X6	Guy's & St Thomas' NHS Foundation Trust Community Services Community health services for adults	Gracefield Gardens	SW16 2ST
RJ1X6	Guy's & St Thomas' NHS Foundation Trust Community Services Community health services for adults	Elmcourt Health Centre	SE27 9AW
RJ1X6	Guy's & St Thomas' NHS Foundation Trust Community Services Community health services for adults	Bowley Close Rehabilitation Centre	SE19 1SZ
RJ1X6	Guy's & St Thomas' NHS Foundation Trust Community Services	Walworth Road Clinic	SE17 1RT

Summary of findings

Community health services for adults

This report describes our judgement of the quality of care provided within this core service by Guy's and St Thomas' 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 Guy's and St Thomas' NHS Foundation Trust and these are brought together to inform our overall judgement of Guy's and St Thomas' NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	6
Background to the service	8
Our inspection team	8
Why we carried out this inspection	8
How we carried out this inspection	8
What people who use the provider say	9
Good practice	9
Areas for improvement	10

Detailed findings from this inspection

The five questions we ask about core services and what we found	11
---	----

Summary of findings

Overall summary

Guys and St Thomas NHS Foundation Trust provided adult community services to support people in staying healthy, to help them manage their long term conditions, acute care delivered in people's homes to avoid hospital admission and following discharge from hospital to support them at home. Services were provided in clinics, outpatient departments and in people's homes.

The service required improvement in the effective and well-led domains.

The trust infection prevention and control policy had not been followed in Dulwich community hospital and Bowley close rehabilitation service.

Shortage of experienced nursing and therapy staff left some teams overstretched. Record keeping was inconsistent. This meant that before they visited nursing staff did not always have a clear understanding of a patient's health status when giving treatment. Staff did not always complete a personalised care plan.

In some community teams staff were out of date with their mandatory training.

There was a clear incident reporting system in place and learning was shared between teams. Community nursing staff had access to specialised equipment to meet patients' needs when required. The service used effective hand hygiene procedures.

Staff gained consent for treatment and involved patients and relatives in decisions. However, healthcare staff tended to refer to other agencies when mental capacity assessments were required. There was a lack of understanding of who the decision maker was and how this information should be recorded.

Staff experienced some difficulties accessing information because the electronic record keeping system was slow and not always available due to connectivity problems. Different health teams had access to different patient record systems, which complicated the process of obtaining up to date information about patients. The Health Inclusion Team did not use the RIO system. They used the EMIS IT system. The Enhanced Rapid Response team, the Supported Discharge Team and the @home team all used RIO and could see the district nursing records.

We found some examples of effective services and improved patient outcomes due to evidence based practice and commitment of staff to promote patient's independence. Staff used evidence based care informed by NICE guidelines. Teams worked together in a coordinated way and made appropriate referrals to specialised services. The service participated in audits and developed action plans to improve.

There was good multi-disciplinary working with a strong focus within teams and clinics to reduce hospital admission and promote early discharge. Services were commissioned and designed with this purpose.

Patients received a caring service.

Staff were kind and respectful towards them. Staff treated patients with dignity, involved patients and their families in their care and supported them during times of crisis. Staff gave clear explanations for treatment and encouraged patients to reach their goals.

Patients and relatives expressed satisfaction with the service and we found a caring and compassionate approach from staff in the areas we visited. We saw examples of initiatives and ways of working across localities that were providing patients with good access to services and treatment.

Community health services for adults were responsive.

We saw there were examples of very responsive and accessible services such as rapid referral and quick assessment. These were provided by rapid response teams, the "@home" and "supported discharge" teams who worked closely together.

Improvements made by some teams had identified areas where easy access and increased support for example, provision of Foot health training in diabetes patients had significantly reduced the incidence of avoidable foot pressure ulcers.

Patient responses to trust surveys we saw told us they were very happy with the response of services where for example they had been seen immediately and their treatment commenced to prevent hospital admission.

Summary of findings

Staff considered the needs of people who may have difficulty accessing services and adapted their care approach to show respect for cultural factors. There was evidence of learning from the complaints received from patients and families.

Many aspects of the service were well led but some aspects of risk management and public engagement needed to be improved.

Staff in adult community services told us they were well supported by local team leaders and managers. Staff across the trust had opportunities to review the quality of care and the way that teams worked. They told us they felt empowered to develop local solutions based on good practice.

There was a clear vision for the service and examples of innovation. Risk registers reflected the key areas of concern to frontline and management staff.

Summary of findings

Background to the service

Guys and St Thomas NHS Foundation Trust provides adult community services to support people in staying healthy, to help them manage their long term conditions, to avoid hospital admission and following discharge from hospital to support them at home.

In April 2011, Lambeth and Southwark's community services joined the trust. Since then the trust has helped to establish the Southwark and Lambeth Integrated care (SLIC), a major programme with local partners to promote joined-up health and social care.

The trust overall has more than 2 million patient contacts each year with 859,000 in community services.

Community healthcare services are provided in 25 centres across Lambeth and Southwark. Services are provided in clinics, outpatient departments and in people's homes. Services provided include: community

nursing services, community therapy services, community intermediate care, community rehabilitation services, community prevention services, health inclusion services and community outpatients services.

Integrated Community Teams (ICT) consist of community nurses, physiotherapy, occupational therapists and specialist nurses who aim to support patients being discharged from hospital back to their own homes.

The "@home" service provided acute level care in the patient's home in place of admission to an inpatient bed. The team was made up of nurses, social workers, therapists and home care workers. The aim of the service was to help people stay well, independent and supported in their own home to enable them to get back into familiar routines and an independent lifestyle.

The Enhanced Rapid Response and supported discharge service offered a timely assessment and rapid social and health care input for patients who were in a "crisis" and would otherwise need a hospital admission.

Our inspection team

Our inspection team was led by Chair: Ellen Armistead
Deputy Chief Inspector Care Quality Commission

Team Leader: Margaret McGlynn Interim Head of Hospital
Inspection Care Quality Commission

The team inspecting this core service included an inspector, an assistant inspector and two specialist advisors.

Why we carried out this inspection

This was a scheduled comprehensive trust inspection.

How we carried out this inspection

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

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

- Is it well-led?

Before visiting, we reviewed a range of information we held about the trust and asked other organisations to share what they knew. We carried out announced visits on 8-10 September 2015 to services across the geographical area. During the visit we held focus groups with a range of staff who worked within the service, such

Summary of findings

as nurses, doctors, therapists. We talked with people who use services. We observed how people's care was being planned and observed multidisciplinary meetings where people's needs were being discussed. We reviewed care or treatment records of people who use services. We looked at and reviewed a range of policies, procedures and other documents relating to the running of the 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 the 16 September 2015.

During the inspection we visited a number of teams based at eight locations. Akerman Health Centre, Townley road Health Clinic, Gracefield Gardens, Elmcourt Health centre, Walworth Road Clinic, Bowley Close rehabilitation unit and Dulwich Community Hospital.

We spoke with a total of 35 staff and observed 32 others. We reviewed the following services: integrated

community teams (which included community nurses, matrons, occupational therapists, and physiotherapists), the health inclusion team, diabetes outpatient services, specialist nursing, enhanced rapid response, supported discharge and @home services. This was in addition to organised drop in sessions where staff were invited to come and speak with us regarding their role and the services provided.

During the inspection we looked at patient care documentation and associated records and observed care in clinics and in a reablement centre. We reviewed meeting minutes, operational policies and staff records.

We spoke with 5 patients in person, 35 staff and observed 32 other staff members; including administrators, doctors, matrons, community nurses and therapists. We spoke with managers and the head of nursing.

We reviewed comment cards and patient friends and family test information received from patients who used trust community services.

What people who use the provider say

We spoke with three relatives/carers and received positive feedback about the care they received.

Carers were positive about the care and treatment their relative had received. One carer said staff were "polite and helpful" another said, "staff are responsive to people's needs" and they were able to ask questions.

Feedback from patient surveys were overwhelmingly positive. We saw data from the 2013-2014 patient friends and family test survey. Patients said the service was "Very Good." Staff "listened to their concerns and carefully explained what was happening."

In July 2015 the trust friends and family test scored 95.4 % for patients who would recommend them out of a sample of 480. Data was available from January 2015. Apart from one month (March 2015) the trust scored over 93% from patients who would recommend them.

Patients were able to feedback in a number of different ways. For example, online ,comment cards available throughout the trust, directly via staff or through patient advice and liaison service (PALs).

Individual teams in the community had devised local patient experience and feedback questionnaires. For example the early rapid response and supported discharge team and the health inclusion team. We were shown example of these on our visit.

Good practice

- The trust had a diabetes information and education service. (Desmond) Staff provided education to newly diagnosed adult diabetic patients and an open

telephone service for staff or patients to access expert advice. The team had been able to identify localities where additional education of patients could improve the management of their condition.

Summary of findings

- The trust had developed an innovative staff education programme aimed at raising awareness of patients living with dementia; “Barbara’s story” had been seen by 12,000 staff and won many national awards.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that care and treatment is only provided with the consent of the relevant person.
- When patients (aged 16 and over) are unable to give consent because they lack the capacity to do so, the trust should ensure staff act in accordance with the Mental Capacity Act 2005
- The trust should ensure that all staff undertake training in safeguarding children at the level relevant to their role.
- The trust should ensure that there are systems in place to identify the cleanliness of equipment.
- The trust should ensure that the environment at Dulwich Hospital is suitable for purpose.
- The trust should review the paper and electronic records to ensure that the recordings are complete, accurate and do not contain variances and discrepancies.
- The trust should ensure that robust arrangements are in place for the management of risk and governance.

Guy's and St Thomas' 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

The safety of community adults services was good, although some areas needed to be strengthened.

There was a clear incident reporting system in place, and learning was shared between teams. Medicines were managed safely. There were systems to monitor the quality and safety of care provided including performance dashboards and the NHS Safety Thermometer.

Staff were aware of the trust's safeguarding procedures and the action to take if they suspected or witnessed abuse. There was good attendance at mandatory training and although there were vacancies the trust had achieved some success with recruiting new staff.

Systems in place to respond to patients telephone messages needed strengthening along with maintaining equipment and monitoring the cleanliness of the environment.

Safety performance

- The service monitored safety information through regular quality dashboard reports on safety indicators such as pressure ulcers, falls and medication errors.
- Guy's and St Thomas' NHS Foundation Trust participated in the NHS Safety Thermometer scheme used to collect local data on specific measures relating to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key area.
- There had been no Never Events reported, which are incidents determined by the Department of Health as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. This data was collected electronically and a report produced for each area.

Incident reporting, learning and improvement

- The trust had systems in place to report and record safety incidents, near misses and allegations of abuse. Between June 2014 and July 2015 a total of 711 incidents were reported by the community service. The

Are services safe?

majority (97%) of the incidents were classified as either low or no harm. Incidents reported included patient accidents, (90) such as falls, pressure ulcers, medication errors (120) and incidents around consent, communication and confidentiality (76). There were clear policies for reporting this and staff told us they knew how to report incidents and were aware of the online reporting tools, policies, procedures and audits.

- Incidents were reported through to managers and reviewed at governance or quality and safety meetings. Key themes and trends and case studies were highlighted. Staff told us there was a good incident reporting culture. Staff said that incident reporting worked well and outcomes were fed back at staff meetings. We saw staff meeting minutes where these were discussed.
- Staff felt changes had taken place and practice changed as a result of incident reporting. Learning from incidents was shared across teams. Staff gave an example of a medication error. This had been reported to the manager and a performance improvement plan had been implemented with the training rolled out across all the relevant teams. This meant there was an effective incident reporting system in place. Learning was shared between teams and staff were proactive in recognising and reporting incidents.
- We viewed a newsletter entitled “Clinical Governance Quality Bulletin” that was sent out to staff monthly. This had “key messages” about incidents where learning was shared for staff to discuss in their own teams. Contact details were included for the “Adult community governance” facilitator who staff could contact for advice and support.
- Staff told us they felt the electronic reporting system, was a good reporting tool although there was an unused potential to use it for positive events. For example; one member of staff told us they used the system to report positive feedback about their care from patients. Most other staff told us they did not do this.

Safeguarding

- Nursing staff were knowledgeable about safeguarding procedures and knew who they would report any concerns to. We saw information about how to report any safeguarding concerns and safeguarding adults information was displayed in the hospital, clinic and community bases we visited.

- The trust Safeguarding Adults Annual Report 2014 – 2015 report stated over the last year they had achieved their training target of 85% set by the local CCGs. In April 2015 they would review the Safeguarding Adults training to “ensure that that Trust training was Care Act 2014 compliant”.
- Training records to September 2015 showed inconsistencies in the numbers of staff that had completed mandatory training. For example: 100% of the supported discharge team had completed Safeguarding Adults training. However the percentage of staff, in some other teams, who had completed training, was below the yearly target set by the trust. For example; Dulwich District nursing was 80%, Enhanced rapid response was 77.3%. Lambeth Adults with Learning Disabilities team was 70%. The trust annual report stated “once the trust has achieved 95% compliance the training will become ‘every 3 years’.
- We saw the trust policy for mandatory training which specified that Level 2 child safeguarding training was mandatory for all clinical staff across the organisation – this included doctors, nursing & midwifery staff and allied health professionals (AHPs). Department training figures showed that 45 out of 65 (69.2%) community nurses in north, south east and south west areas listed had completed level 2 training.
- Guidelines published by the Royal College of Paediatrics and Child health in March 2014 recommend that level two is the minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers. Staff in community nurse teams all told us they were very busy with high workloads and prioritising training was difficult when referrals were increasing.
- The trust had developed a pocket sized booklet which identified the trust processes to follow for any concerns.
- The trust Safeguarding Adults Annual Report 2014 – 2015 stated referrals from community teams had increased significantly over the last year representing a 132% rise in numbers. This was highlighted as a “positive change in practice”. One of the key challenges faced by community staff were supporting patients and or their carers who refused appropriate care and treatment. Patients sometimes had the mental capacity to refuse treatment.

Are services safe?

Medicines

- Community staff used Guys and St Thomas Hospital (GSTT) medication administration records (MAR) that were transcribed by the nurse and checked by second nurse as required in the protocol. The pharmacy inspector looked at MARs from the district nursing teams at Akerman Health Centre and the “at home” service at Walworth Road. They found these were completed clearly and accurately detailed the patients prescribed medicines which were recorded in the records and on the electronic patient record system.
- The “@home” service at Walworth Road stored medicines to be taken out with the doctor. These were stored in a sealed bag in a locked cupboard. Medicines included those needed to be able to manage patients care in an emergency, and medication that might be needed to immediately start a course of treatment. The storage bag was returned to pharmacy after use for replenishing. We saw a list of medicines on the bag but no expiry date recorded on the outside of sealed bag. This meant that if staff did not check every medication expiry date every time it was opened then not all medication might be in date and safe to be used. When staff were made aware of this during the inspection they contacted pharmacy to correct this.
- Nurses ruck sack of kit included glucose drinks for hypoglycaemia or low blood glucose (these happen when your blood glucose level drops too low). These were routinely checked by nurses and spot checked by senior staff on a regular basis. We saw records that confirmed this.
- The trust were employing a pharmacist and a pharmacy technician to work alongside the nursing team for a one year contract initially. Currently all district nurses had phone numbers of GSTT pharmacists and could call them to discuss any concerns or ask for advice. We saw anecdotal evidence that this resource was being used widely.
- Independent nurse prescribers prescribing medication were audited by the trust pharmacist. The audit concluded that all staff were compliant with current medication legislation and guidance.
- All medicines administered were prescribed by the GP or nurse prescriber. No patient group directives (PGDs), which are prescriptions that staff sign and can be used

generically for patients were in use except flu vaccines for staff. The nurse prescriber would be giving flu vaccines to housebound patients this winter under a PGD.

- The tissue viability specialist service had agreed the list of dressings used by the nursing teams according to most recent available best practice. They regularly updated the nursing teams on any changes that were advised and attended regional meetings to share good practice.
- Nurse’s packs contained anaphylaxis kits that were in date and regularly checked.
- Antibiotic guidelines for treatment in the community with intravenous fluids (IV) and oral medicines were agreed with GSTT and Kings College hospital to ensure a consistent approach across the localities.
- The trust completed an audit of the Health Inclusion Team (PGD) compliance for minor ailments which they said was “satisfactory”.

Environment and equipment

- Most staff in community teams said access to standard pressure relieving cushions and mattresses was not a problem, although they sometimes had to wait. We saw one incident where this had been identified as a contributory factor to patient developing a pressure ulcer.
- Staff told us they asked advice of the tissue viability specialists when required. Care plans we saw detailed the severity and improvement of pressure ulcers. Appropriate pressure relieving equipment was in use, however incidents we saw and discussion with staff raised concerns that equipment was not always available when it was required. For example, a pressure cushion was requested but when it did not arrive it was not followed up by the team. Consequently the patient’s pressure ulcer deteriorated further. We saw learning had taken place and systems put in place to monitor equipment requests.
- There were no records of staff competency checks prior to using rehabilitation equipment.
- There were no risk assessments in place for gym equipment. Details regarding which patients had used this equipment were not traceable. This meant staff were unaware whether equipment was safe for patients to use.

Are services safe?

- At Bowley Close rehabilitation service wheelchairs were made on site, however there was a four months wait for wheelchairs. The waiting time for a wheelchair could be extended by the need for home adaptations to accommodate a wheelchair, or for patients requiring a more complex prescription, although this was not the case for all wheelchair orders. Staff told us this meant patients were using wheelchairs that were not the right size for them as they were given whatever was available to use while they waited. In some cases this meant patients were unable to go out until their wheelchair had arrived as there were none suitable.
- The trust responded in June 2015 with an interim solution for district nursing teams to have their mobile phones upgraded. Staff could use their mobile phone to photograph their paper record entries to enable later electronic entry via email and cut and paste to the progress record. The trust told us all district nursing teams had their mobile phones upgraded, but at the time of our inspection visit we found that not all staff had an upgraded phone.
- During the inspection nursing staff had raised concerns about duplicate entries into systems. They told us that busy workloads, system connection issues and IT systems that did not talk to each other meant records were not always updated. This meant we could not be assured patient's records contained all relevant information.
- The system in place for recording messages from patients to district nursing teams, the action taken and the outcome were not accurately maintained.

Quality of records

- Trust information stated that all staff had completed Information governance training and the community nursing department had 100% compliance.
- The trust community risk register listed multiple IT issues disrupted efficient working and resulted in additional time for administrative tasks. The trust was in the process of piloting a range of mobile working devices which were being assessed for usefulness before being rolled out to teams.
- Staff recognised how important it was to keep the information up to date on the system. However they told us that due to connectivity problems, shortages of staff and the time taken to complete records online they often spent time in the office at the end of a shift, or after days off, to complete records including incident records.
- Regular audits were undertaken to monitor quality of patient's records. However these were not effective in ensuring risks to patients quality of care were highlighted. For example, in November 2014 the risk register identified concerns raised by community nursing staff which stated there were inaccuracies and inconsistencies in record keeping due to keeping a dual set of records. The trust identified this presented a clinical risk to patients due to increased clinic activity, leading to a backlog in typing and filing. Nurses had to duplicate records to make an entry into the patient held paper record and then to make an electronic entry on RIO at some point later in the day, which the trust identified "results in inaccuracies between what is recorded on paper and electronically because it relies upon memory".

Cleanliness, infection control and hygiene.

- Most community bases and clinic environments we visited were clean and free from clutter. Hand hygiene gels, paper towels and rubbish bins were plentiful. However, at Dulwich hospital we found the hospital was in the process of being decommissioned which meant that some areas were no longer in use and others that were poorly maintained. For example, a clinical waste bin was found in one of the toilets instead of the recycling bin or waste paper bin. In one waiting area there were a mixture of chairs with some that could be wiped clean and others that could not. This meant those that were not able to be wiped clean could not be cleaned effectively.
- We requested the latest infection Prevention and Control Audit Report from the trust for the hospital. The report was completed dated 16/09/2015. It highlighted that some areas of the hospital were noncompliant with the trusts infection prevention and control policy. This included, "Visibly worn out vinyl flooring with multiple scratch marks and elevated boarded area that is not well secured" that required urgent action. In other clinical rooms the audit identified a stained sink with no mixer taps, a hand washing sink had a sink plug that had been requested to be removed at the previous audit over two years ago.

Are services safe?

- At Bowley Close rehabilitation centre they had no up to date record of when rehabilitation equipment was last cleaned and serviced. For example, the cleaning schedule for therapy plinths was not up to date; the most recent entry was dated August 2015 and prior to that May 2015
- Regular hand hygiene audits demonstrated high compliance rates throughout the department and infection control guidelines were clearly displayed in the outpatients department. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- Patient quality and safety information provided by the trust for hand hygiene target was 90%. The year to date (YTD) average score for the last 12 months was 98.9% which was above the target
 - Hand hygiene audits were carried out both in the community and in clinic settings. One manager told us all staff had regular observations carried out on their infection control practices. If there were any concerns identified then staff underwent a rigorous re training and further observation of practice until compliant. Staff were encouraged and supported to review their hand hygiene practices regularly.

Mandatory training

- The trust had set themselves a high target of 95% on the Adult community Performance review scorecard for staff completing mandatory training. The YTD average was 87.3%.
- Staff in the different teams described good access to mandatory training. They told us their mandatory training was up to date and it was reported that the trust had a strong focus on training.
- Staff told us their mandatory training included, infection control and moving and handling. E-learning courses were also available in a number of subjects including safeguarding and equalities and diversity.

Assessing and responding to patient risk

- We looked at how district nursing team ensured messages received in teams from patients and professionals were actioned. In Ackerman and Elmscourt DN teams they kept a message book. When messages came into the teams they would be written in the book. Staff told us it was the Band 6 and 7 nurse's responsibility to check the book and action messages. Staff signed and ticked the message to say it had been dealt with and they did not need to put the date in when they signed.
- In Ackerman and Elmscourt DN teams we picked 10 messages for each team from the previous month, both those ticked and signed and those not ticked as actioned. We looked to see if any information about the message and outcome had been recorded on the patient's electronic RIO records.
- In Ackerman we found six out of 10 messages did not have any information about the outcome recorded on the patients file. For example; a patient had rung in to ask for a change in the size of incontinence pads as they were the wrong size. There was no record on the file whether this had been actioned and replacements ordered for the patient.
- In Elmscourt DN team seven out of 10 records had no information on the outcome of the message. For example, a message dated August 2105 said that a catheter was leaking badly and visit was requested. The last case notes recorded were June 2015. Staff checked diaries and saw that the patient was visited. It had been an agency nurse who does not have access to the IT system. Staff told us agency nurses do not always have access to the IT system because it takes so long to get the approvals through and accounts set up.
- The managers had assured us that even if not ticked in the message book all messages would have been responded too but staff were busy and did not always follow the process. We asked them if they audited and checked to see if staff were following the process. They said they did not audit the message book. They relied on staff to do what was required. This meant they had no way of knowing whether staff were following up messages and requests from patients as this information was not recorded.
- Due to inconsistencies in record keeping, teams did not always have a clear overview of the patient's medical status over time. This was important when managing patients with complex pathologies in community settings who were at risk of deterioration.
- Staff told us duplicate referrals were often sent to rapid response, at home and district nursing teams for the same person at the same time. Staff said they would have to check with other teams and discuss together

Are services safe?

who was most appropriate to follow up. Staff relied on working closely with other teams and discussing on the telephone directly to ensure patients received the most appropriate service from the relevant team. This meant staff could not rely on referral information on its own. Staff told us duplicate referral happened because inpatient services needed to discharge patients quickly. Duplicate referrals were sent in the hope they would be allocated quickly. This meant that patients being discharged from hospital were less likely to be lost in the system but increased the workload of community teams while they decided which service was most appropriate.

- Staff in the district nursing team said sometimes they sometimes did not know that referrals had been duplicated and it was not until they arrived at the patient's house they saw paper information from other teams who were also involved. At that point they would discuss with other professionals who would be most appropriate. They said this happened frequently and particular when urgent visits were requested for same day visits.
- Moving and handling plans were completed by nursing staff and available for all staff when they cared for patients in their own homes.
- Lead nurses told us they completed malnutrition universal screening tool (MUST) nutrition and hydration assessments when completing an assessment of patient care. We looked at four archived paper records and saw that only one had had a MUST completed. Two records did not have the Waterlow score for assessing risk of developing pressure sores completed. We were unable to ascertain whether any of the patients without an assessment of risk had developed pressure sores.

Staffing levels and caseload

- The trust adult community workforce performance review identified areas where they were not meeting targets. For example; the community vacancy rate for permanent staff was targeted at 15% but the year to date (YTD) average was 25.6% which means that there were significant gaps in some teams that were being filled by agency staff if available. The trust's budget for agency usage was set at 5%, The YTD average was 21.2% of budget being used for agency staff. Staff told us that when agency staff were not available they worked additional hours to cover the work.

- Some teams had high numbers of agency staff. The manager told us it was a challenge to keep up with the high turnover of agency staff but they tried to keep the same agency staff for as long as possible. Agency and permanent staff were all very positive about their work and managers said that recruitment was an ongoing struggle. Managers told us they tried to ensure patients were seen by the same staff whenever it was possible but the nature of the service and working pattern of staff meant that was not always possible.
- The trust were aware of the difficulties teams experienced in recruiting and had looked at a number of ways to recruit staff. They had just completed recruitment for 450 newly qualified nurses who would be disseminated throughout the trust with a number being placed in community nursing services to fill shortfalls.
- Staff at all grades told us that staffing levels were too low in many community teams. We found staffing issues were raised with inspectors for more than half of the 13 teams we spoke with.
- The effects of being short of staff in some areas impacted on patient care. Staff told us there had been times when they were not able to make the expected visit to patients or went much later than planned. They prioritised according to patient need and adjusted their workload to manage the demand on their time. Staff told us they regularly worked over their contracted hours.
- Staff in all areas told us they often completed patient records, paper and electronic, in their own time. Pressure of work was also felt when staff attended training and no replacement was made. They said they prioritised patients over training as patients had to be seen. One manager told us they had asked the trainer to come to the office and provide the training there. Staff planned their workload to attend and this had worked well but was not always possible to do.
- There was no caseload management tool in use to measure acuity or dependency of patients in the community. The integrated community teams were developing a process to review caseloads but this was not yet implemented. This meant that management did not have detailed oversight of the demands on staff and the capacity available in teams. After the inspection the trust told us the 'batman' tool, which determines units of care for patients based on acuity was used to allocate work on a daily basis. We did not see this in use and

Are services safe?

staff made no reference to it when discussing caseload management tools at the time of our inspection. The trust also told us a capacity planning tool is used which is shared weekly with the directorate management team, the Chief Nurse and the Chief Operating Officer; the trust sent us an example for January 2016. We did not see this in use and staff made no reference to it when discussing caseload management tools at the time of our inspection.

- The board community risk register identified: community nursing staffing pressures, insufficient staff to meet demand, not all staff are skilled and confident to provide all care and high vacancy rate in allied health care professional (AHP's) Measures to address recruitment and retention, comprehensive inductions for new staff and skills training have been put in place.
- Managers told us they accepted there were challenges in recruitment and workforce capacity.

Managing anticipated risks

- Rapid response teams had access to a number of pool cars if required.
- Where risks had been identified prior to a visit all staff took appropriate measures to ensure they were safe.
- Staff were provided with emergency alarms and buddy and checking systems were in place to ensure staff returned safely when they said they would.

- Rapid response, supported discharge and the at home teams helped to discharge patients from accident and emergency and intermediate care beds by proactively liaising with staff and providing urgent care services in the patient's home.
- Staff in the rapid response teams covered between localities to relieve pressures when needed. The rapid response service had a high number of agency staff working in the service. Managers told us recruiting staff was difficult but a recent recruitment campaign had meant more permanent staff would be in post by the end of the year.

Major incident awareness and training

- There was a business continuity plan regarding major incidents. It identified key contact details and a process for staff to follow.
- At local level community nursing teams told us they had systems in place to make sure people got visits despite bad weather. For example; Patients who did not need to be seen would be telephoned to check their health and welfare.
- Rapid response, supported discharge and the at home service had access to local police and ambulance transport services should that be needed in an emergency.

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

Deprivation of Liberty Safeguards were not always understood and mental capacity was not always appropriately assessed and recorded for patients who may lack capacity. Staff were knowledgeable about the need to act in patient's best interest but were not clear about who could consent on the patient's behalf and how this information should be recorded in patients' records.

The service participated in audits and developed action plans to make improvements. Patients were given a choice of options to manage their pain.

There was a key focus of many teams and clinics to reduce hospital admission and promote early discharge. This was aligned to the commissioning of services designed with this in mind and to promote independence in patients. However this meant that teams received duplicated referrals and patients could have more than one set of paper records from those involved. This information was not accessible to either team unless they physically read the notes at the patient's home.

Teams worked together in a coordinated way and made appropriate referrals on to specialised services to ensure that patients' needs were met. However district nurses were not always informed of patients' discharge from hospital, which meant patients did not always get a timely visit.

Staff used clinical guidelines and protocols to inform their decisions about care and treatment. Services were delivered in line with evidence based practice. Staff with specialist skills and knowledge were used by community teams to provide advice or direct support in planning or implementing care.

Evidence based care and treatment

- The trust participated in and initiated a number of national and local audits. For example ARU, falls management audit. The National audit of Intermediate care (NAIC).
- We saw evidence that the trust had reviewed a number of audits both local and national in May 2015. These included a review of the Occupational (OT) Therapy

service auditing their practice against the college of OT guidelines in several settings, including home visits to patients with lower limb prostheses. This resulted in a "revised home assessment" that would include falls prevention assessment on each visit". This was a change in the assessment information that was gathered and increased the frequency of falls prevention assessments.

- National Institute for Health and Care Excellence (NICE) guidance was used by staff. Staff told us that to keep up to date they used the trust website, and received monthly trust bulletins and emails from managers regarding updates to NICE guidance. Staff referred to NICE guidelines in discussions. Policies and procedures quoted NICE and other professional guidance.
- The trust used some relevant best practice and NICE guidance to develop services and care and treatment were delivered. For example; latest guidance on treatment of leg ulcers.
- We saw the leg ulcer pathway which detailed a holistic assessment (0-4 weeks) and a bandage and hosiery guide. This followed current best practice guidelines on the application of different layers of bandages used. Contact details of the tissue viability nurse both phone and e-mail were easily accessible. Staff confirmed they regularly contacted the teams for advice and information.
- Research and clinical audits were carried out on the efficacy and suitability of treatments – For example IV versus sub cutaneous fluids for re-hydration and oral medication versus IV furosemide for heart failure. This meant staff were ensuring they used the most effective methods to manage patient's health condition.
- Medication audits were regularly undertaken and outcomes monitored. If any issues were raised, then immediate training would be arranged and targeted where needed.
- The intranet was available to all staff and contained links to current guidelines, policies and procedures.

Pain relief

- Patients' care plans included when relevant appropriate pain assessment and managements plan. For example,

Are services effective?

staff used a sliding scale from nought to ten, with ten being severe pain. Staff told us this was “sufficient” and worked well as patients found it easy to understand and respond.

- In a multi-disciplinary meeting, professionals discussed options for pain relief including use of a patch to enable a patient to have more sustained relief from pain which would facilitate their independence in activities of daily living.
- The health inclusion team had a specialist who worked with patients who had chronic pain secondary to traumatic experiences. The team provided outreach health care to patients who had difficulty accessing primary health services; for example this included homeless people, refugees, asylum seekers and patients with addictions.

Nutrition and hydration

- Lead nurses told us they completed malnutrition universal screening tool (MUST) nutrition and hydration assessments when completing an assessment of patient care. We looked at four archived paper records and saw that only one had had a MUST completed. This meant staff were not following trust guidance in ensuring they completed a full assessment on patients when referred to the service.

Patient outcomes

- Staff used outcome measures to monitor patient progress. Key outcome measures were Braden Assessment of pressure ulcer risk and nutrition scoring.
- Falls and wound audits were undertaken and changes were documented in patient records. Patient’s paper records were kept in their home.
- The intermediate care (ERR/SDT) and @home teams together with the local authority Reablement teams took part in the National Audit of Intermediate Care, which enabled the trust to benchmark reablement services against over 200 similar services. The audit focussed on home based intermediate care and reablement.
- Staff said that patients with diabetes and/or their carers received a structured educational programme that fulfilled the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education. This was called ‘Desmond’ (Expert for Type 2 Diabetes) and was a self-management programme. The specialist doctor and nurse showed us information

patients were given. They gave us information on the self-management programme and we saw information leaflets and posters on the walls in the clinic that informed patients what subjects were covered. For example, healthy eating and foot health.

- The stop smoking teams re-audit of recommendation of combined nicotine replacement therapy showed that uptake last year had increased from 61% to 81% in Lambeth. This was as a positive result of the action plan set in place after last year’s audit when figures were low.

Competent staff

- The trust adult community "performance review scorecard" on workforce set a target for appraisal of 95%. The year to date (YTD) average was 71%. Many staff told us their teams had vacancies. The trust was proactive in trying to recruit but finding suitably qualified staff was difficult.
- Other teams for example the health Inclusion team were fully staffed and staff said staff rarely left as they enjoyed their work.
- There was evidence that agency staff competency was checked on recruitment. Most staff received appraisals and all staff had opportunities for further training. For example, band 5 nurses could apply for a year course designed to give nurses who are either newly qualified or just new to the community all the skills and competencies they need for autonomous working.
- An induction process was in place for new and agency staff. Staff in different teams showed us copies of their local induction process. We spoke with two new staff members in different team’s one permanent and one agency member of staff. They found both the trust wide induction and their local team induction useful.
- Managers told us they had developed a specialised induction for newly qualified nurses that would enable them to gain the skills they needed. Some staff had been acting up to band 6 posts. Work had also focussed on improving the skills of unqualified staff to relieve the workload of band 5 staff.
- Staff in the different teams described good access to mandatory training and additional specialist training when required. There was regular supervision and appraisal of staff. Team meetings were used to provide peer group supervision and case study discussion.
- Pressure ulcer training e-learning was devised as part of the tissue viability team’s joint working with Kings

Are services effective?

Health partners. This was available for staff to access in May 2015. The training was suitable for all clinical staff involved in providing patient care and was developed because of the difficulty staff had in attending training. It contained all the information staff required to identify, manage and monitor pressure ulcers and was composed of five-ten minute modules. Once staff had completed they would be sent a certificate to use for their training portfolio.

Multi-disciplinary working and coordinated care pathways

- We observed virtual ward rounds and multidisciplinary meetings. There was good professional input from specialists and medical staff where present. Staff were clear about progress and next steps for patients. The care plan was reviewed through discussion with staff who had visited the patient. Plans for progress and resolution of issues for patients were decided.
- The Bowley Close rehabilitation service had close multidisciplinary working and effective links to the community therapy team's links that extended out of the borough. This meant patients had a care plan that clearly identified their needs. Patients were involved in discussions and if additional resources were needed staff approached organisations outside the borough that could help. For example, ex-soldiers could access charity organisations like "help the heroes" for assistance with additional equipment not covered by the health service.
- Lambeth and Southwark boroughs had higher than the national average numbers of patients with diabetes. The service had developed close links with GP surgeries and patients had access to drop in clinics and specialist nurses who could change and prescribe medication if needed.
- Staff in community teams told us that multidisciplinary team (MDT) working was good. Staff felt able to consult with colleagues and there was a good rapport within the different specialists. We found examples of effective multidisciplinary working both within and across teams. For example specialist nurses were available for staff to consult and gain advice and support from. These included specialists in for example tissue viability, multiples sclerosis and palliative care.
- The at home service had access to specialist consultants and doctors as well as therapists. They could refer patients directly into acute services if needed. Staff all said they worked well together and worked collaboratively with the patient at the centre.
- Community teams were described by staff as busy teams that were supportive of staff but had deadlines and targets to meet.
- The at home service provided an in reach service to GSTT and KCH. The team had access to specialist doctors, for example a consultant geriatrician and could refer directly in to acute or outpatient services if needed.

Referral, transfer, discharge and transition

- Some care pathways overlapped. For example, occupational therapists and physiotherapy staff worked in the rapid response, supported discharge and at homes teams they could move between services if needed. This meant services were flexible and responded quickly to ensure patients received appropriate care and support when it was needed.
- The acute hospital in reach teams facilitated timely discharge from acute hospitals and had good communication with community teams. However, district nursing teams gave examples where they were not always made aware that patients had been discharged from hospital and they needed to visit. They usually did not find out until the patient rang and asked them why they had not visited. They told us they did not keep a record of how often this happened but said it happened on a regular basis.
- Community teams had close working relationships with social workers and GPs and liaison with hospice and palliative care services when needed we were given examples of joined up working across these services that had taken place for one patient that meant they had the care they needed when they needed it.
- The enhanced rapid response, supported discharge and at home teams provided a comprehensive service to patients requiring additional support on discharge from hospital. The at home team provided clinical care in patients own homes that are normally routinely carried out as an inpatient. for example intravenous drugs. The enhanced rapid response, supported discharge teams and district nursing teams provide urgent access within two hours if needed and access to a range of therapy staff including physiotherapy and occupational therapy staff.

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We spoke with staff who explained procedures for gaining consent from patients before delivering care and treatment.
- For example; community nursing patients signed consent forms on a paper copy which were kept in patients' homes. Staff told us they did not keep a copy of this information in the office as all care took place in patients' homes. Outcomes for each visit were written on paper copies kept in patients' homes. We looked at the IT system notes and five paper records from patients' homes that were being archived. Of five paper records for consent four were signed but only two by the patient, the other two were signed by a family member with no legal power to sign. One member of staff told us this is regular practice as they assume consent and never ask for evidence of power of attorney but assumed families acted in the patient's best interests. If they thought they did not then they would get further advice from their manager. They did not routinely record this on the IT system as a best interest decision.
- Staff at all levels including managers were unclear how much information they needed to record on care notes and the format this should take when making best interest decisions for patients who could not consent. We were given examples where nursing staff routinely asked family members to consent for the patient. For example, a senior nurse prescribed insulin for a patient who had a learning disability and could not consent. Consent was agreed with the family who did not have the legal power to agree. The senior nurse said they did not record this in the patients care records as a best interest decision. Some staff said they assumed consent unless the patient showed they did not want to comply with a request even though they knew the individual could not consent due to their health condition. For example, in patients with severe dementia. They did not record this intervention as a best interest decision in care records. Mental Capacity Act (2005) code of practice states that responsibility for deciding what is in a person's best interest lies with the member of healthcare staff responsible for the person's treatment. They should record their decision, how they reached it and the reasons for it in the person's clinical notes.
- Staff had received mandatory training on Safeguarding Adults, Mental Capacity Act (2005) (MCA) and

- Deprivation of Liberty Safeguards (DoLs). Staff were confident about seeking consent from patients but not confident about what process they should follow if patients did not have capacity.
- We observed staff discuss mental capacity assessments at community team multi-disciplinary meeting. They recognised the need to document assessments and decisions and said they documented these in case notes.
 - The trust policy on recording mental capacity act assessments detailed what information had to be recorded in case notes. The trust safeguarding adult's annual report completed an audit of records in 2014-2015 to see if they complied with the requirement of the act. Records were audited to identify if patients were: formally assessed for the ability to make care and treatment decisions that were required of them if the two-stage capacity test was used and if the results were recorded in detail. The records were also audited to identify where results of the capacity tests were recorded and if best interest meetings or discussions were had and recorded.
 - Twenty two health records were audited in quarter four (October 2014 to December 2104). The recording of the two stage test showed improvement with over 80% of the health records audited demonstrating detailed records of the findings of the two stage capacity test. 86% of the records that were audited demonstrated a record of all the four components of the functional aspect of the capacity test compared to 50% in the previous quarter. This audit was completed in February 2015. However the report did not detail which services the sample of 22 records were from so we were unable to identify if any of the audited records were from community services. This was a small sample of the "more than 2 million patient contacts" the trust has each year; 800000 of which were in community services. This meant the trust could not be assured that all staff were complying with the requirements of the act.

Access to information

- Staff raised concerns about the IT systems in use. Broadband connections were slow and sometimes did not work at all. This had been raised but there had been no action yet. This meant that staff were at times unable to access referral and health information about patients before they visited.

Are services effective?

- The risk register stated that the service was reliant on temporary staff and this meant it was important to get staff set up on RIO very quickly, because new and temporary staff did not have a RIO (IT) diary. Staff told us their patient appointments had to be recorded against a different member of staff. This meant that for audit and investigation purposes it was sometimes difficult to see who had made a visit to a patient. Agency staff told us they were reliant on permanent staff inputting patient information for them. For example, if they responded to telephone messages, they were then not able to enter the outcome on electronic patient records. We checked ten electronic patient records at three offices we visited where telephone messages had been received by the office. We found in over half the records there was no outcome recorded on the electronic patient records. Whilst auditing of records was undertaken this did not highlight any concerns. This meant the trust was unaware of the extent of the problem and there were no effective audit process in place to check. The trust had a plan in place to integrate IT and software systems over a period of time.
- The majority of teams we visited were using agency staff that did not have access to their own blackberry phones. They often did not have access to the trust IT systems due to delays in the processes and training required to enable access. This was reported as a risk on the risk register in November 2014. It stated that "delays in obtaining RIO (IT) access and smartcards mean that staff can be without RIO access for some weeks / months. ... appointments do not get outcomes unless some-one else does them and the activity is therefore lost to the service." This confirmed what staff had told us that this was a problem. The risk was reviewed in September 2015 and the trust requested a "Fast track RIO (IT system) set up and access for district nursing". At the time of our inspection this was in progress.
- Paper records were kept at the patient's home for all people involved in the person's care to document their actions, conversations and the patient's wishes and outcomes. This meant healthcare professionals involved in the patient's care, who visited them at home, had access to up to date information and knew of any changes or developments in the patient's health. However, not all information was transferred to the nursing IT system (RIO)
- Information was available on standard operating procedures and contact details for colleagues within and out of the organisation. This meant that staff could access advice and guidance easily.
- Staff had access to interpreting and translation services and could arrange both face to face and telephone interpreting services as required.
- The trust had produced written information for people accessing the community health service. For example; information was available on healthy eating. Written leaflets could be requested, when required, in a different language or format.

Are services caring?

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

Summary

Patient survey information told us the staff providing services were caring. We observed care and treatment provided by the trust staff was undertaken in a kind and caring way.

Staff were caring and compassionate, treated patients with dignity and respect and recognised their individual needs.

Few of the records we looked at included assessing patient's emotional needs or included care plans that addressed this. However we found that in discussions with staff they gave examples and referred to practice that demonstrated they had considered the patients emotional needs although this was not always well documented.

Compassionate care

- The friends and family test response rate was low at 4.1% of patients responding. A number of staff had identified difficulties in getting completed responses returned. For example, district nurses left the card with carers and patients but not many were returned although those that were very positive about the patient experience. Comments included, "very happy with the service received".
- During our inspection we observed the interactions between staff and patients in the health centres, clinics and community hospital.
- We looked at patient feedback information and complaints the trust had received. The information indicated that staff in the trust treated patients with care and compassion.
- Staff in specialist nursing teams told us they regularly received positive feedback from GPs with compliments from patients who used services. Teams such as the multiple sclerosis nurses showed us thank you card from grateful patients.

- Staff in multidisciplinary meetings demonstrated knowledge, skill and a caring attitude towards patients during their discussions.
- We saw that clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics.
- We observed staff greeting patients in a friendly, but appropriate manner. One patient told us staff were "very caring".

Understanding and involvement of patients and those close to them

- Staff supported patients to manage their own health care and maximise their independence. For example, we observed a health care assistant talking to a patient and giving practical advice to increase their mobility.
- Staff in the diabetic and high risk foot clinic gave verbal and written advice to patients to help them manage their condition.
- Diabetic patients were encouraged to participate in self-assessment and monitoring of their condition.

Emotional support

- Patient survey information confirmed that the majority of patients felt listened to and that staff understood their needs.
- Staff told us they worked together to ensure care was as coordinated as possible.
- Staff had good awareness of patients with complex needs and those people who may require additional support should they display anxious or challenging behaviour during their visit. The multiple sclerosis specialists carried out a comprehensive assessment that included information on how they could meet patient's emotional needs.
- The at home and rapid response service completed holistic assessments that identified patients emotional support needs. Staff gave us examples of the how they had provided emotional support to patients.

Are services responsive to people's needs?

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

Summary

The services provided a range of specialist therapeutic interventions. The trust was aware of the diverse needs of the people who used the service and they provided a range of support as required.

There were good examples of staff and teams working responsively to reduce hospital admissions, and promote faster discharge. Rapid response teams and rapid access services acted quickly when patients needed support to initiate treatment and care packages. Access to leg ulcer clinics and the health Inclusion service meant that patients had health care support, advice and treatment in their local area. Access to prosthetics and rehabilitation for people who needed this service was quick; however there was a four month wait for wheelchairs that impacted on patients.

Problems with connectivity, slow systems and different IT systems that did not talk to each other were raised by all staff we spoke with. One member of staff said they could "come to work switch on their computer, go and make a drink, have breakfast and they were likely to still have to wait for the system to start". This impacted on their work as they had limited time in the office before going out visiting. The trust were aware of the problems as it was on the risk register.

Planning and delivering services which meet people's needs

- The trust had identified a need to increase the number of diabetic clinics, due to the demand for services. Additional locations were in the process of being sourced and organised to offer a more accessible service.
- Patients attending the diabetic and high risk foot clinic were seen regularly, usually every three months, for a review of their condition and treatment.
- The trust had a team of tissue viability nurses who were supporting trust staff, and those in local care homes, in the prevention, early identification and treatment of pressure ulcers.
- Bowley Close rehabilitation service was commissioned through central NHS England for 11 boroughs. We saw there was a strategy and vision for the prosthetic and

wheelchair service, and risks about waiting times for wheelchairs were on the trust risk register. However we could not find evidence of any service development for the assistive communication team. This meant that patients might not have access to communication aids that would be important to enable them to communicate and socialise with other people.

- There was an in-reach service provided to secure early discharge from hospitals. The service was flexible and seen as effective. The service could help to develop urgent packages of care at home for people who were still at risk of falling.

Equality and diversity

- Staff told us that specialists could be contacted if support was required when working with people with learning disabilities. We were given an example by nursing staff where the team had been contacted by the accident and emergency department for advice about a patient with a learning disability. This had facilitated their admission and the community team had an outreach service to visit patients in hospital.
- Trust wide, 94% of nursing staff and 99% of therapy staff had received training on equality, diversity and human rights.
- Translation services were available and staff we spoke with were clear about how to access these services

Meeting the needs of people in vulnerable circumstances

- There were good multi-professional links with the acute hospital and other community service for the prosthetic service.
- The London Dementia Strategic Clinical Network released new guidance for dementia training for health and social care staff in London involving three tiers of training for staff which will be commensurate with their roles and responsibilities. Barbara's Story DVD collection was cited as a good example of Tier 1 training which is dementia awareness training. Tier 1 training had been

Are services responsive to people's needs?

offered at corporate induction which consists of Barbara's Story (DVD 1) and the other five DVDs recommended as Tier 2 dementia training, have been included in the Level 2 Dementia training offered to staff.

- Every member of Trust staff had been recognised as a Dementia Friend by the Alzheimer's Society. Normally, to become a Dementia Friend, you would need to attend a one hour Information Session, run by a Dementia Friends Champion. However, following an evaluation by the Alzheimer's Society, the Barbara's Story induction session had been recognised as covering the same key messages and resulting in as positive an outcome.
- A communication booklet had recently been developed as a resource to help staff to communicate with patients with dementia. 1000 copies have been printed and were being disseminated to staff.
- The Trust Dementia strategy together with a Dementia Care Pathway called "Get it Right for Me" had been developed that will drive the Dementia agenda over the next 3 years. Embedding the key priorities of the Dementia Strategy will enable the Trust to achieve Dementia Friendly Hospital Status. 2015 will see the start of the implementation of the Dementia strategy across the Trust.
- Community matrons had a referral target per month of 140. The YTD average achieved by the service at March 2015 was 70 referrals, which was below the number set by the trust target.
- The Enhanced Rapid Response (ERR) team were set up to promote early discharge from hospital with support from therapists for approximately six weeks if required to help patients manage at home while still having rehabilitation. The trust had set the ERR team an accepted referrals target of 95%. The team caseload target was 100 and the YTD average was 135, which meant teams were accepting more referrals and performing above the target.
- Staff told us they responded to urgent referral requests the same day and could respond within two hours if required. Non urgent referrals would be followed up the next day. Triage arrangements were in place to ensure referrals were prioritised appropriately.
- The trust operational efficiency targets included "at home" referrals target of 369 with an YTD average completion of 286. Whilst the YTD average did not meet the target the number of patients seen was an increase on the previous year. The caseload target for this team was 85 with an YTD average of 56. They were not meeting this target but this was an increase on the previous year.

Access to the right care at the right time

- The adult community scorecard information for the year ending March 2015 showed the trust achieved an average of 99% for consultants' complete pathways (referral to treatment (RTT) within the 18 weeks target) against the trust's own target of 95%. In the year to date (YTD) at the time of our inspection the trust achieved 98.2%.
- The adult community scorecard information for the year ending March 2015 showed the trust achieved an average of 97% for consultant's incomplete pathways against the trust's own target of 92%. In the year to date (YTD) at the time of our inspection the trust achieved 94.8%.
- The trust operational efficiency targets included recording the amount of patient facing time for district nurses for the year ending March 2015 showed the average was 36% against the trust's own target of 40%. In the year to date (YTD) at the time of our inspection the average was 47.3%.
- The District nursing (DN) teams in Lambeth had a single point of access (SPA) arrangements to screen referrals into the service. Other teams had their own systems. For example, in the Rapid Response service (RRS) referrals were sent to individual teams based on the patient's GP. Staff in both services triaged the calls and prioritised urgent referrals such as falls, palliative care, prevention of admission and facilitating discharge.
- Staff shared collective responsibility between teams and services. For example; referrals could be sent to both district nursing and rapid response teams by the ward for the same patient. Staff in both teams said they would telephone and discuss who would be best to progress the referral. This meant patients would receive the right care from the right team straight away.
- The trust had admission avoidance teams responding to patient need to avoid admission to hospitals. These included enhanced rapid response and health inclusion teams.

Are services responsive to people's needs?

- Schemes for discharge were very dependent on domiciliary care and reablement provision commissioned by social care. These included the supported discharge and “at home” service.
- Patients with clinical care needs could be supported via the “at home” service in the community freeing up inpatient beds and enabling patients to be supported in their own home. This service supported acutely unwell adults with nursing needs. For example, patients requiring intravenous fluids and nursing care for a period of time. The team was made up of nurses, social workers, therapists and home care workers. The aim of the service was to help people stay well, independent and supported in their own home to enable them to get back into familiar routines and an independent lifestyle. They provided a seven day service and had had a doubling of referrals in last six months. Once patients’ immediate nursing needs were met they were referred on if needed to the rapid response service. They could provide additional support and rehabilitation for up to six weeks.
- At Bowley Close rehabilitation centre we saw patients had quick access to the service. Appropriate assessments were undertaken. There was a short two week waiting list for prosthetic and physiotherapy assistive care. Custom made prosthetics were made on site

Learning from complaints and concerns

- Nursing staff across all teams told us that most complaints to nursing services were about missed visits. Action had been taken locally across teams that wherever possible staff would contact patients if going to be later than expected.
- Information about themes from complaints across community teams identified that as well as missed visit, timing of visits, shortage of staff resulting in rushed visits and communication with family members were themes identified as raising complaints.
- Most staff we spoke with raised similar themes and gave us examples. They told us they were doing what they could to minimise problems identified by patients. Staffing pressures meant they could not always accommodate people’s wishes around time of visits or rushed visits but where they could they did.
- There were clear arrangements for complaints; leaflets and advice were available within patient information files in their homes and at community bases and clinics. Staff told us that complaints were fully investigated and learning was fed back at team meetings.

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

Arrangements for governance and need to be improved.

There was a limited approach to obtaining the views of patients who use services. Where changes were made, the impact was not always monitored.

Staff were aware of trust vision and values and their local support arrangements. Some knew who the chief executive was and some members of the board, but were less clear about the management arrangements in between.

The trust supported staff engagement and development including a quality programme which staff said was empowering and focused on improvement. Staff were encouraged to share ideas to improve practice and share their specialist expertise with other staff and teams.

The trust supported staff engagement and development including a quality programme which staff said was empowering and focused on improvement.

Service vision and strategy

- The trust had a community business plan and had set objectives to be delivered between 2014 and 2016.
- Consultation had taken place and plans were in progress to adopt and integrate practices and teams across Lambeth and Southwark boroughs to ensure “high quality local services with excellent health outcomes for patients”. However this was not yet in place and team practice was not integrated. We saw each local team had their own way of managing the service within their area. Vacancies in teams meant progress was slow as everyone was busy managing day to day work.
- Staff were aware of the trust vision in “putting people first” and took pride in what they did. There was a clear focus on patient care.

Governance, risk management and quality measurement

- The service maintained a register identifying risks to the service with details of existing controls and mitigating actions. There were 49 risks identified on the Adults

community services risk register (updated July 2015).

Some of the concerns we found during the inspection were included on the risk register, such as inaccuracies and inconsistencies in record keeping due to keeping a dual set of records. However, others such as the high use of agency staff were not.

- We found governance arrangements for managing the risk register were not robust and did not always provide positive assurance that risks were managed well. For example; there were four risks included on the register in November 2014 that did not include controls or actions despite a review date of July 2015. These risks were: the potential to miss community visits because of lack of clear alert in the electronic scheduling system, tracking of patient records in adult community nursing, the lack of training and non-adherence to trust manual handling policy in community settings and the lack of a standard operating procedure for phlebotomy.
- The service did not have oversight and plans to mitigate some of the risks identified during the inspection. This included risks related to a lack of understanding about obtaining consent from patients who may lack capacity, DoLS and the need to ensure all environments used to provide patient care should meet infection prevention and control guidance
- All teams had regular team meetings, for example local district nurse teams had daily team meeting with all staff where they shared learning on incidents, fed back on patients’ needs and agreed plans for the next day.
- We saw three sets of minutes for the monthly band seven team leader meeting for all professional groups. Staff completed governance templates for the month which included information on the numbers of complaints and number of pressure ulcer. Information was shared and case studies used to support the discussion and learning shared.
- There was a lone working policy in place to support staff working out in the community. Staff were aware of the

Are services well-led?

lone working policy and used this consistently. In team meetings, practical issues with the policy were discussed and resolved. We saw minutes from three community teams that confirmed this.

- Unqualified staff working evening or twilight shifts told us they worked in pairs for safety. In some teams, for example rapid response teams, unqualified staff doubled up after 5pm. Managers told us this practice was historical and did not apply to qualified staff.

Leadership of this service

- The senior management team was led by the Director of Operations and Strategic development who had overall responsibility for all Adult services. The Adult Community Directorate general manager was responsible for amongst others, specialist and regional rehabilitation services, health inclusion and prevention specialist services.
- The head of nursing was responsible, amongst others, for district nursing, standards and practice, clinical governance and the “@home” service.
- The head of local Rehabilitation and Integrated care manager was responsible amongst others, for community Intermediate care, community rehab and falls service, and neurological rehabilitation services.
- Most staff told us that their local management was very supportive. They said they were listened to and felt that managers would act on their behalf. They were aware of the heads of professions and divisional directors' names, although many staff told us they had not met members of senior management.

Culture within this service

- There was a strong culture of teamwork and a focus on key outcomes such as reducing hospital admissions or pressure ulcer incidence. In one team one new staff member said it was the best team they had worked in, and that the team appreciated the different skills they could bring to the group.
- One administrator told us they felt part of the team and supported nurses with telephone messages or patient contact. Nursing staff reported that the administrator roles were essential for the team in managing the volume of referrals and ensuring phone calls were answered.

- Staff told us about the negative effects of staff shortages in some teams and this was affecting morale. They regularly worked over their contracted hours or felt the care they could offer was compromised at times. All staff were confident that the trust knew about the problems and were doing their best to recruit more staff as soon as they could.
- Staff told us there was an open, honest and transparent culture for dealing with complaints and incidents.

Public engagement

- There were examples of patients being involved in service development. These included patient survey feedback and learning from complaints. The trust had identified it had a poor response rate to friends and family test patient surveys and were looking at ways to improve the response.
- Staff told us community patients should be given a copy of the patient survey when staff discharge patients. Staff did not keep a record of how many were returned so were unaware of the reason why patients did not complete them. One member of staff commented they thought patients would not return them as they could be identified.
- We saw positive feedback from patients in all areas we visited both from thank you cards received and from anonymous patient feedback survey.

Staff engagement

- Most staff told us they felt community services were not a priority for the trust. They felt part of the organisation but the acute side was the priority. The community and acute service had integrated in 2011 and staff highlighted the improvement in communication and development of more community services that had occurred since that point. Staff were aware of trust values and felt these were translated in their day to day work with patients.
- Information from the trust was regularly sent to staff by email and news letter. Staff were encouraged to look at the staff intranet. However, community staff told us newsletter did not often include information about community teams or reflect the value and role of the community services they tended to focus on the acute trust information.

Are services well-led?

- We saw the trust held over 25 staff engagement activities between November 2014 and June 2015. These were varied, covered different topics and included events and workshops. For example, in February 2015 a Health Inclusion and Prevention services away day took place to share and celebrate achievements in service delivery and reflect on improvements to practice. In June 2014 a catheter pathways/cobweb systems event took place that asked staff to think about what could be done in the future for catheter care. Some staff told us they had been involved in some of these events either as a participant or as a lead for the service. However other staff told us it was difficult to attend events and workshops as they were so busy and could not be released to attend.
- Staff said that some initiatives were in response to Government expectations, for example: falls and dementia strategies but they said they felt involved in the planning and development of services.
- Staff told us that there had been difficulties with use of electronic patient care record for teams. The structure of some forms was confusing and not always appropriate for therapy staff needs. Care plans were being developed with staff as part of the planned move to a different case notes system.
- Nursing staff told us they were developing a new assessment form that will be included in the new system. The development team for electronic patient records had been working with the teams to meet the different clinical recording requirements.

Innovation, improvement and sustainability

- Staff told us the trust was an inclusive organisation and it encouraged staff to innovate in line with its core business.